Neighborhood Health Plan
OF RHODE ISLAND™

Neighborhood **INTEGRITY** (Medicare-Medicaid Plan)

2024 Member Handbook

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Neighborhood Health Plan of Rhode Island INTEGRITY *Member Handbook*

January 1, 2024 – December 31, 2024

Your Health and Drug Coverage under the Neighborhood Health Plan of Rhode Island (Neighborhood) INTEGRITY Medicare – Medicaid Plan

Member Handbook Introduction

This handbook tells you about your coverage under Neighborhood INTEGRITY (Medicare-Medicaid Plan) through December 31, 2024. It explains health care services, behavioral health coverage, prescription drug coverage, and long-term services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

This Neighborhood INTEGRITY plan is offered by Neighborhood Health Plan of Rhode Island. When this *Member Handbook* says "we," "us," or "our," it means Neighborhood Health Plan of Rhode Island. When it says "the plan" or "our plan," it means Neighborhood INTEGRITY.

Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-844-812-6896 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-844-812-6896 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-844-812-6896 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-844-812-6896 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-844-812-6896 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-844-812-6896 (TTY 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-812-6896 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-844-812-6896 (TTY 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-844-812-6896 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم 1-844-812-6896 (TTY 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-844-812-6896 (TTY 711) पर फोन करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है।

È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-844-812-6896 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-844-812-6896 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-844-812-6896 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-844-812-6896 (TTY 711). Ta usługa jest bezpłatna.

当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-844-812-6896 (TTY 711)にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដើម្បីឆ្លើយរាល់សំណួរដែលអ្នកអាចមានអំពីគម្រោងសុខភាព និងថ្នាំរបស់យើងខ្ញុំ។ ដើម្បីទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ គ្រាន់តែហៅទូរសព្ទមកយើងខ្ញុំតាមរយៈលេខ 1-844-812-6896 (TTY 711)។ អ្នកដែលនិយាយខ្មែរជួយអ្នកបាន។ នេះជាសេវាកម្មឥតគិតថ្លៃ។

You can get this document for free in other formats, such as large print, braille, or audio. Please call Member Services at 1-844-812-6896, 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. TTY users should call TTY 711. The call is free.

You can ask to get this document and future materials in your preferred language and/or alternate format by calling Member Services. This is called a “standing request”. Member Services will document your standing request in your member record so that you can receive materials now and in the future in your preferred language and/or format. You can change or delete your standing request at any time by calling Member Services.

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Disclaimers

- Neighborhood Health Plan of Rhode Island is a health plan that contracts with both Medicare and Rhode Island Medicaid to provide benefits of both programs to enrollees.
- Coverage under Neighborhood INTEGRITY is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.
- If you get or become eligible for long-term services and supports, you may have to pay part of the cost of these services. This is known as "cost-share," and the amount is determined by Rhode Island Medicaid.

Chapter 1: Getting started as a Member

Introduction

This chapter includes information about Neighborhood INTEGRITY, a health plan that covers all your Medicare and Rhode Island Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from Neighborhood INTEGRITY. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Welcome to Neighborhood INTEGRITY

Neighborhood INTEGRITY is a Medicare-Medicaid Plan. A Medicare-Medicaid plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has a care manager and a care team to help you manage all your providers and services. They all work together to provide the care you need.

Neighborhood INTEGRITY was approved by the State of Rhode Island and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the Integrated Care Initiative.

The Integrated Care Initiative is a demonstration program jointly run by Rhode Island and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medicaid health care services.

B. Information about Medicare and Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medicaid

Medicaid is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. In Rhode Island, Medicaid is called Rhode Island Medicaid.

Each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and Rhode Island must approve Neighborhood INTEGRITY each year. You can get Medicare and Rhode Island Medicaid services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the State of Rhode Island approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Rhode Island Medicaid services will not be affected.

C. Advantages of this plan

You will now get all your covered Medicare and Rhode Island Medicaid services from Neighborhood INTEGRITY, including prescription drugs. **You do not pay extra to join this health plan.**

Neighborhood INTEGRITY will help make your Medicare and Rhode Island Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You may have a care manager. This is a person who works with you, with Neighborhood INTEGRITY, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care manager.
- The care team and care manager will work with you to come up with a care plan specifically designed to meet your health needs. The care team will be in charge of coordinating the services you need. This means, for example:
    - Your care team will make sure your providers know about all medicines you take so they can reduce any side effects.
    - Your care team will make sure your test results are shared with all your doctors and other providers.

D. Neighborhood INTEGRITY's service area

Our service area is the State of Rhode Island.

Only people who live in our service area can get Neighborhood INTEGRITY.

If you move outside of Rhode Island, you cannot stay in this plan. Refer to Chapter 8, Section J for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan Member

You are eligible for our plan as long as:

- you are 21 years old or older, **and**
- you live in our service area (Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it), **and**
- you have both Medicare Part A and Medicare Part B and are eligible for Part D, **and**
- you are a United States citizen or are lawfully present in the United States, **and**
- you are eligible for Rhode Island Medicaid.

F. What to expect when you first join a health plan

When you first join the plan, you will get an assessment within the first 90 days.

Someone from our care management team will contact you by phone to complete the assessment with you. Based on your needs, you may receive a more comprehensive assessment within 45 days of your enrollment effective date. The comprehensive assessment will take a deeper look at your needs, capabilities, and services that you may require.

If Neighborhood INTEGRITY is new for you, you can keep using the providers you use now for 180 days.

After 180 days, you will need to use doctors and other providers in the Neighborhood INTEGRITY network. A network provider is a provider who works with the health plan. Refer to Chapter 3, Section D for more information on getting care.

G. Your care plan

Your care plan is the plan for what health services you will get and how you will get them.

After your assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make your care plan.

Every year, your care team will work with you to update your care plan if the health services you need and want change.

H. Neighborhood INTEGRITY monthly plan premium

Neighborhood INTEGRITY does not have a monthly plan premium.

I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9, Section D, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at 1-844-812-6896. You can also refer to the *Member Handbook* at www.nhpri.org/INTEGRITY or download it from this website.

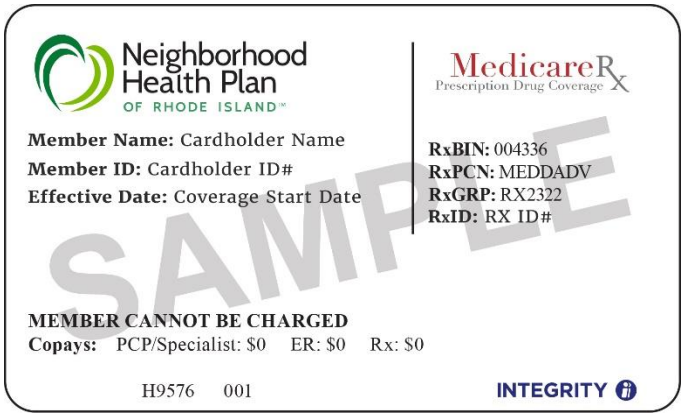
The contract is in effect for the months you are enrolled in Neighborhood INTEGRITY.

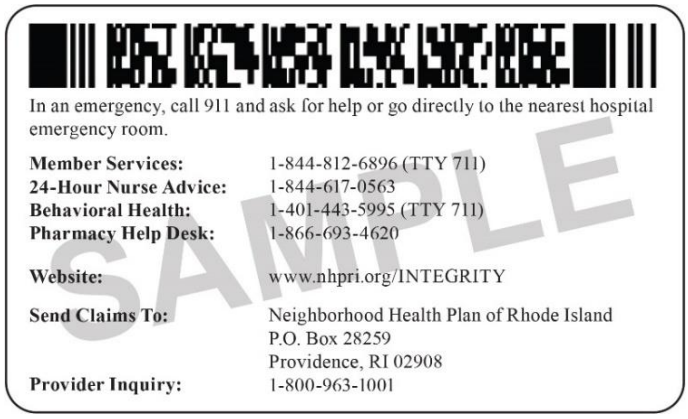
J. Other important information you will get from us

You should have already gotten a Neighborhood INTEGRITY Member ID Card, information about how to access a *Provider and Pharmacy Directory*, a List of Durable Medical Equipment, and information about how to access a *List of Covered Drugs*.

J1. Your Neighborhood INTEGRITY Member ID Card

Under our plan, you will have one card for your Medicare and Rhode Island Medicaid services, including long-term services and supports and prescriptions that are covered by the Neighborhood INTEGRITY plan. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:





If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a Member of our plan, you do not need to use your red, white, and blue Medicare card or your Rhode Island Medicaid ("anchor") card to get services that are covered by Neighborhood INTEGRITY. Keep your Medicare card in a safe place, in case you need it later. **Use your Rhode Island Medicaid ("anchor") card for dental services and non-emergency medical transportation (NEMT).** Refer to Chapter 4 for more information about when to use your Rhode Island Medicaid ("anchor") card. If you show your Medicare card instead of your Neighborhood INTEGRITY Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7, Section A to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Neighborhood INTEGRITY network. While you are a Member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (refer to page 35).

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at 1-844-812-6896. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at www.nhpri.org/INTEGRITY or download it from the website.

The Provider and Pharmacy Directory lists health care professionals (such as doctors, nurse practitioners, and psychologists), facilities (such as hospitals or clinics), and support providers (such as Adult Day Health and Home Health providers) that you may see as a Neighborhood INTEGRITY Member. It also lists the pharmacies that a Member may use to get prescription drugs.

The Provider and Pharmacy Directory contains provider and pharmacy address and contact information, as well as, other details such as days and hours of operations, specialties, and skills for all providers and pharmacies in the Neighborhood INTEGRITY network.

Definition of network providers

- Neighborhood INTEGRITY 's network providers include:
    - Doctors, nurses, and other health care professionals that you can use as a Member of our plan;
    - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Rhode Island Medicaid.

Network providers have agreed to accept payment from our plan for covered services as payment in full. If you get or become eligible for long-term services and supports, you may have to pay part of the cost of these services. This is known as "cost-share," and the amount is determined by Rhode Island Medicaid.

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan Members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at 1-844-812-6896 for more information. Both Member Services and Neighborhood INTEGRITY's website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Durable Medical Equipment (DME)

With this *Member Handbook*, we sent you Neighborhood INTEGRITY's List of Durable Medical Equipment. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at www.nhpri.org/INTEGRITY. Refer to Chapter 4 to learn more about DME.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by Neighborhood INTEGRITY.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to Chapter 5, Section C for more information on these rules and restrictions.

Each year, we will send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit www.nhpri.org/INTEGRITY or call 1-844-812-6896.

J4. The *Explanation of Benefits*

When you use your Part D prescription drug benefits, we will send you a summary to help you understand and keep track of payments for your Part D prescription drugs. This summary is called the *Explanation of Benefits* (or EOB).

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. Chapter 6 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services.

You have the option to receive your Part D Explanation of Benefits electronically. The electronic version provides the same information and in the same format as the paper Explanation of Benefits that you receive today. To begin receiving electronic Explanation of Benefits, go to www.caremark.com or call Member Services to register. You will receive an e-mail notification when you have a new Explanation of Benefits to view. Be sure to keep these reports. They are important information about your drug expenses.

K. How to keep your membership record up to date

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you**. Because of this, it is very important that you help us keep your information up to date.

Let us know the following:

- changes to your name, your address, or your phone number
- changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- any liability claims, such as claims from an automobile accident
- admission to a nursing home or hospital
- care in an out-of-area or out-of-network hospital or emergency room
- changes in who your caregiver (or anyone responsible for you) is
- you are part of or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

If any information changes, please let us know by calling Member Services at 1-844-812-6896.

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8, Section C1.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Neighborhood INTEGRITY and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. How to contact Neighborhood INTEGRITY Member Services

CALL	1-844-812-6896 This call is free. 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays you may be asked to leave a message. Your call will be returned within the next business day. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays you may be asked to leave a message. Your call will be returned within the next business day.
WRITE	Neighborhood Health Plan of Rhode Island Attn: Member Services 910 Douglas Pike Smithfield, RI 02917
WEBSITE	www.nhpri.org/INTEGRITY

A1. When to contact Member Services

- questions about the plan
- questions about claims, billing or Member ID Cards
- coverage decisions about your health care
    - A coverage decision about your health care is a decision about:
        - your benefits and covered services, **or**
        - the amount we will pay for your health services.

- Call us if you have questions about a coverage decision about health care.
- To learn more about coverage decisions, refer to Chapter 9, Section D.

- appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
  - To learn more about making an appeal, refer to Chapter 9, Section D.
- complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint to us or to the Quality Improvement Organization about the quality of the care you received (refer to Section F below).
  - If your complaint is about a coverage decision about your health care, you can make an appeal (Refer to the section above).
  - You can send a complaint about Neighborhood INTEGRITY right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - To learn more about making a complaint about your health care, refer to Chapter 9, Section J.
- coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs, **or**
    - the amount we will pay for your drugs.
  - This applies to your Part D drugs, Rhode Island Medicaid prescription drugs, and Rhode Island Medicaid over-the-counter drugs.
  - For more on coverage decisions about your prescription drugs, refer to Chapter 9, Sections E and F.
- appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - You can a request an appeal for your Medicaid or Part D prescription drugs by calling Member Services at 1-844-812-6896 (TTY 711). Drugs that are not Part D drugs are coded as “DP” in our Drug List; these are Medicaid drugs.

- For more on making an appeal about your prescription drugs, refer to Chapter 9, Sections E and F.

- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above).
  - You can send a complaint about Neighborhood INTEGRITY right to Medicare. You can use an online form www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to Chapter 9, Section J.

- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7, Section A.

    If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9, Section E3 and F5 for more on appeals.

B. How to contact your care manager

A Care Manager is a licensed clinician (either a Registered Nursed (RN) or a social worker) who helps you manage all of your providers and services. They work with your Care Team to make sure you get the care you need. If you choose, you may have a Care Manager to help coordinate your care. To request, change, or contact a Care Manager, call Member Services.

CALL	1-844-812-6896 This call is free. 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays you may be asked to leave a message. Your call will be returned within the next business day. We have free interpreter services for people who do not speak English.

TTY	711 This call is free. 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays you may be asked to leave a message. Your call will be returned within the next business day.
WRITE	Neighborhood Health Plan of Rhode Island ATTN: Care Management 910 Douglas Pike Smithfield, RI 02917
WEBSITE	www.nhpri.org/INTEGRITY

B1. When to contact your care manager

- questions about your health care
- questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)

Individuals who have a high or highest level of care need, and who otherwise would need institutional care, may be eligible for Long-Term Services and Supports (LTSS) in their home. LTSS is a variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance and improve the quality of their lives so they can safely remain in the community.

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

- skilled nursing care
- physical therapy
- occupational therapy
- speech therapy
- medical social services
- home health care

C. How to contact the Nurse Advice Call Line

A Nurse Advice Line is available 24 hours a day, 7 days a week. The nurses can help you with deciding on the best place to go for care, like your doctor, urgent care, or emergency room. They can also help answer questions about your health concerns, questions about medications, and what you can do at home to take care of your health.

CALL	1-844-617-0563> This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week

C1. When to contact the Nurse Advice Call Line

- questions about your health care

D. How to contact the Behavioral Health Crisis Line

The Behavioral Health Crisis Line provides in person information and support to members in need of locating and accessing behavioral health or substance use services.

CALL	1-401-443-5995 This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week

D1. When to contact the Behavioral Health Crisis Line

- questions about behavioral health services
- questions about substance use disorder services

E. How to contact the State Health Insurance Assistance Program (SHIP) and the Medicare-Medicaid Enrollment Supports Program (MME)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Rhode Island, the SHIP is provided by the Office of Healthy Aging (OHA).

The Medicare-Medicaid Enrollment Supports Program (MME) gives free one-on-one health insurance counseling to people with Medicare and Medicaid. In Rhode Island, the MME is provided by The POINT.

The SHIP and The POINT are not connected with any insurance company or health plan.

CALL	Rhode Island SHIP: 1-888-884-8721 8:30 am to 4:00 pm, Monday – Friday The POINT: 1-401-462-4444 8:30 am to 4:00 pm, Monday – Friday
TTY	711
WRITE	Office of Health Aging, Louis Pasteur Building 57 Howard Avenue Cranston, RI 02920 Attention: SHIP Program
WEBSITE	www.oha.ri.gov

E1. When to talk to a SHIP counselor

- questions about your Medicare health insurance
    - SHIP counselors can answer your questions about changing to a new Medicare plan and can help you:
        - understand your plan choices,
        - understand your rights,
        - make complaints about your health care or treatment, **and**
        - straighten out problems with your bills.

E2. When to talk to an MME counselor

- questions about your options for health insurance because you are eligible for Medicare and Medicaid
    - MME counselors at The POINT can help you:
        - understand your health insurance choices through one-on-one options counseling,
        - understand your rights,
        - straighten out any problems with Medicaid eligibility, **and**
        - access temporary Part D prescription coverage if needed

F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called KEPRO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KEPRO is not connected with our plan.

CALL	1-888-319-8452
TTY	1-844-843-4776 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	KEPRO 5700 Lombardo Center Drive, Suite 100 Seven Hills, OH 44131
WEBSITE	www.keproqio.com

F1. When to contact KEPRO

- questions about your health care
  - You can make a complaint about the care you got if you:
    - have a problem with the quality of care,
    - think your hospital stay is ending too soon, **or**
    - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up to date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Rhode Island Medicaid

Medicaid helps with health care and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call Rhode Island Medicaid.

H1. General information about Medicaid programs

CALL	1-855-697-4347 8:30 am to 3:30 pm, Monday – Friday
TTY	711
WRITE	Virks Building, 3 West Road, Cranston, RI 02920
WEBSITE	www.dhs.ri.gov

H2. Information about Medicaid Long-Term Services and Supports (LTSS)

CALL	1-401-574-8474 8:30 am to 3:30 pm, Monday - Friday
TTY	711
WRITE	DHS Long-Term Services and Supports P.O. Box 8709, Cranston, RI 02920
EMAIL	dhs.ltss@dhs.ri.gov
WEBSITE	www.dhs.ri.gov
FAX	1-401-574-9915

I. How to contact the RIPIN Healthcare Advocate

The RIPIN Healthcare Advocate works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The RIPIN Healthcare Advocate also helps people enrolled in Neighborhood INTEGRITY with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-855-747-3224 8:00 am to 5:00 pm, Monday - Friday
TTY	711
WRITE	300 Jefferson Boulevard, Warwick, RI 02888
EMAIL	HealthcareAdvocate@ripin.org
WEBSITE	www.ripin.org/services/

J. How to contact The Alliance for Better Long Term Care

The Alliance for Better Long Term Care is an ombudsman program that helps people learn about nursing homes and other long-term care settings. It also helps solve problems between these settings and residents or their families.

CALL	1-401-785-3340 or 1-888-351-0808 9:00 am to 4:30 pm, Monday – Friday
TTY	711
WRITE	422 Post Road, Suite 204 Warwick, RI 02888
WEBSITE	www.alliancebltc.org

K. Other resources

The **Rhode Island Office of Healthy Aging** helps provide information to Rhode Island seniors, families, and caregivers. Some programs and services include but are not limited to, case management, heating assistance, legal assistance, Rhode Island Medicaid Long Term Services and Supports (LTSS), and reporting elderly abuse.

CALL	1-401-462-3000
TTY	711
WRITE	Office of Healthy Aging 25 Howard Avenue, Bldg. 57 Cranston, RI 02920
WEBSITE	www.oha.ri.gov

The **Department of Human Services (DHS) Information Line** provides general information about the Supplemental Nutrition Assistance Program (SNAP), General Public Assistance (GPA) and other agency programs.

CALL	1-855-697-4347
TTY	711
WEBSITE	www.dhs.ri.gov/DHSOffices/index.php

Crossroads Rhode Island offers information on affordable housing for families and individuals, education and employment services, in addition to 24 hours a day, 7 days a week emergency services.

CALL	1-401-521-2255
TTY	711
WRITE	160 Broad Street Providence, RI 02903
WEBSITE	www.crossroadsri.org

The **Rhode Island Disability Law Center (RIDLC)** is an independent nonprofit law office designated as Rhode Island's Federal Protection and Advocacy System. They help provide free legal assistance to individuals with disabilities.

CALL	1-401-831-3150
TTY	711
WRITE	Rhode Island Disability Law Center Inc. 33 Broad Street, Suite 601 Providence, RI 02903
WEBSITE	www.drri.org

The **United Way of Rhode Island** provides free and confidential information about assistance with human services needs such as housing food and childcare.

CALL	211 or 1-401-444-0600
TTY	711
WRITE	50 Valley Street Providence, RI 02909
WEBSITE	www.uwri.org

Chapter 3: Using the plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Neighborhood INTEGRITY. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information about "services," "covered services," "providers," and "network providers"

Services are health care, long-term services and supports (LTSS), supplies, behavioral health, prescription and over-the-counter drugs, equipment, and other services. Covered services are any of these services that our plan pays for. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4.

Providers are doctors, nurses, and other people who give you services and care. The term providers also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services. However, if you are eligible for long-term services and supports (LTSS), you may have to pay part of the cost of the services. This is known as "cost-share," and the amount is determined by Rhode Island Medicaid.

B. Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

Neighborhood INTEGRITY covers all services covered by Medicare and most services covered by Rhode Island Medicaid. This includes behavioral health and long-term services and supports. However, certain Medicaid benefits will still be covered through Rhode Island Medicaid, such as your dental and non-emergency medical transportation (NEMT) services. We can help you access those services.

Neighborhood INTEGRITY will generally pay for the health care and services you get if you follow plan rules. To be covered by our plan:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4 of this handbook).
- The care must be **medically necessary.** Medically necessary means you need services to prevent, diagnose, or treat a health-related condition, to prevent a health-related condition from getting worse, or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment or drugs meet accepted standards of medical practice.

- You must have a network **primary care provider (PCP)** who has ordered the care or has told you to use another provider**.** As a plan Member, you must choose a network provider to be your PCP.
    - You do not need a referral from your PCP for emergency care, urgently needed care, behavioral health care, or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to page 34.
    - To learn more about choosing a PCP, refer to page 33.
    - **Note:** For at least the first 180 days you are enrolled in our plan, you may continue to use your current providers, at no cost, if they are not a part of our network. This is known as a continuity of care period. During the first 180 days you are enrolled in our plan, our care manager will contact you to help you find providers in our network. After the continuity of care period ends, we will no longer cover your care if you continue to use out-of-network providers.
- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
    - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care means, refer to Section I, page 39.
    - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. Your provider must submit a prior authorization and get approval from Neighborhood before you receive the service. In this situation, we will cover the care at no cost to you. To learn about getting approval to use an out-of-network provider, refer to Section D, page 33.
    - The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
    - When you first join the plan, you can continue using the providers you use now for 180 days after you first enroll, or until your care plan is complete.
    - Family planning services are available to you from any provider. You do not need an authorization for these services.

C. Information about your care manager

C1. What a care manager is

- A Care Manager is a licensed clinician (either a Registered Nursed (RN) or a social worker) who helps you manage all of your providers and services. They work with your Care Team to make sure you get the care you need.

C2. How you can contact your care manager

- Your Care Manager's direct number will be listed in your care plan under the care team information.
- You can also contact your Care Manager by calling Member Services and requesting to speak with your Care Manager at 1-844-812-6896 (TTY 711) between 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays, you may be asked to leave a message. Your call will be returned within the next business day. This call is free.

C3. How you can change your care manager

- You can request to change your Care Manager by calling Member Services at 1-844-812-6896 (TTY 711) between 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays, you may be asked to leave a message. Your call will be returned within the next business day. This call is free.

D. Care from primary care providers, specialists, other network providers, and out-of-network providers

D1. Care from a primary care provider

You must choose a primary care *provider* (PCP) to provide and manage your care.

Definition of "PCP," and what a PCP does for you

Your Primary Care Provider (PCP) is your main provider and will be responsible for providing many of your preventive and primary care services. Your PCP will be a part of your Care Team. Your PCP will help you:

- Develop your care plan:
- Determine your care needs:
- Recommend or request many of the services and items you need:

- Obtain prior authorizations from your Care Team or Neighborhood INTEGRITY as needed; and
- Coordinate your care.

Your PCP can be one of the following providers, or under certain circumstances, even a specialist:

- Family Practice;
- Internal Medicine;
- General Practice;
- Geriatrics;
- Gynecology;
- Certified Nurse Practitioner (CNP);
- Physician Assistant (PA);
- Certified Nurse Midwife

You cannot select a clinic (RHC or FQHC) as your primary care provider, but if the provider you select works at a clinic and meets the criteria, that provider can be your primary care provider.

Your choice of a PCP

You can choose any primary care provider in our network. You can find a list of participating providers on our website at www.nhpri.org/INTEGRITY. Please contact Member Services by calling 1-844-812-6896 (TTY 711) if you need help finding a participating PCP in your area. If you do not choose a PCP, we will assign one for you.

If you have already chosen a PCP and that provider is not listed on your member ID card you may contact Member Services to request to have this changed by calling 1-844-812-6896 (TTY 711).

Option to change your PCP

You may change your PCP for any reason, at any time during the year. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP if the one you have now leaves our network. If you do not choose a new PCP, we will assign one for you.

If you would like to change your PCP call Member Services at 1-844-812-6896 (TTY 711).

We will change your PCP effective as of the date of the request and mail a new member ID card to you.

D2. Care from specialists and other network providers

A specialist is a provider who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

It is very important to talk to with your primary care provider (PCP) before you see a specialist. Neighborhood does not require you to have a referral to see specialists. However, you should keep your PCP and your Care Manager informed of any changes in your health.

After seeing a specialist, they may order other services or drugs which may require a prior authorization. A prior authorization means that you must get approval from Neighborhood before getting a specific service, drug, or see an out-of-network provider. Normally your provider would send Neighborhood a letter or form that explains the need for the service or drug. To learn more, refer to the Benefits Chart in Chapter 4.

Your PCP selection does not limit you to specific specialists or hospitals. If you need assistance finding a specialist you can ask your PCP or visit our website www.nhpri.org/INTEGRITY to view our Provider and Pharmacy Directory. If you need help you can also call Member Services at 1-844-812-6896 (TTY 711).

D3. What to do when a provider leaves our plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to care from a broad network of qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will help you select a new qualified in-network provider to continue managing your health care needs.

- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the options you may have for changing plans.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. The out-of-network specialist must submit a prior authorization and get approval from Neighborhood before you receive the service.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to make a grievance or appeal (refer to Chapter 9 for information on filing grievances and appeals).

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care by calling Member Services at 1-844-812-6896 (TTY 711).

D4. How to get care from out-of-network providers

If a provider is not in our network, you or your provider will be responsible for contacting us to get the authorization for your out-of-network visit. Our team of health care clinicians will review all prior authorization requests. There may be certain limitations to the approval, such as the number of visits. If the services are available within our plan's network, the request for the services may be denied. You always have the right to appeal.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid.
- If you use a provider who is not eligible to participate in Medicare and/or Medicaid, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare and/or Medicaid.

E. How to get long-term services and supports (LTSS)

Long-term services and supports (LTSS) are benefits that can help you with everyday tasks like bathing, dressing, grocery shopping, laundry, and taking medicine. Most of these services are provided in your home, but they could also be provided in a facility such as an assisted living facility or a nursing home. As a member of Neighborhood INTEGRITY, you will receive an assessment to help determine your LTSS needs. LTSS benefits are available if you qualify for them and if you meet Rhode Island

Medicaid Long Term Care eligibility. If you require these services they will be included in your care plan, which you help create with your care team.

Services available include:

- Skilled nursing home care
- Physical therapy
- Minor environmental modifications (home accessibility adaptations)
- Respite care
- Homemaker services
- Transition coordination/services

If you need help with getting these services, contact your Care Manager who will assist you in the process to determine if you meet Rhode Island Medicaid Long Term Care eligibility. To contact your Care Manager, call Member Services at 1-844-812-6896 (TTY 711).

F. How to get behavioral health services

Mental health and substance use services are called behavioral health services. Behavioral health services are available to all Neighborhood INTEGRITY members. Optum™ is the behavioral health benefits and network manager for Neighborhood Health Plan of Rhode Island.

You will receive an assessment to help determine any behavioral health needs. If you need behavioral health services, they will be included in your care plan, which you help create with your Care Team.

If you have a behavioral health question, issue, or crisis, call 1-401-443-5995, 24 hours a day, 7 days a week. TTY members call 711. This call is free. We have free interpreter services for people who do not speak English.

G. How to get self-directed care

G1. What self-directed care is

- Self-directed care is the option of hiring your own personal care attendants (PCA).

G2. Who can get self-directed care

- Members who are eligible for and receive long-term services and supports (LTSS) have the option of getting self-directed care. To participate in self-directed care, call your Care Manager by calling 1-844-812-6896 (TTY 711).

G3. How to get help in employing personal care providers

- If you choose to participate in self-directed care, you or your designee would be responsible for recruiting, hiring, scheduling, training, and if necessary, firing your PCA. Self-direction of PCA services is voluntary. The extent to which members would like to self-direct is the member's choice.
- The Rewarding Work website is an online resource that helps members who participate in self-directed care find available PCA's to employ. For more information, go to www.RewardingWork.org , or call your Care Manager.

H. How to get transportation services

You may be eligible for a reduced fare RIPTA bus pass. To get a reduced fare RIPTA bus pass, visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903 or the RIPTA Customer Service Office at 705 Elmwood Avenue, Providence, RI 02907. Call RIPTA at 1-401-784-9500 for more information or visit www.ripta.com/reducedfareprogram.

If you are unable to use a RIPTA bus pass, Rhode Island Medicaid covers non-emergency medical transportation (NEMT) services for rides to medical, dental, or other health-related appointments. If you need routine NEMT, call 1-855-330-9131 (TTY 711), 5:00 am – 6:00 pm, Monday – Friday, or Neighborhood INTEGRITY Member Services at 1-844-812-6896 (TTY 711). **When scheduling NEMT, use your Rhode Island Medicaid ("anchor") ID card.**

You may ask for urgent care transportation 24 hours a day, 7 days a week. Schedule transportation for non-urgent care **at least** 48 hours before your appointment.

Call to schedule on:	**If you need a ride on:**
Monday	Wednesday
Tuesday	Thursday
Wednesday	Friday, Saturday, or Sunday
Thursday	Monday
Friday	Tuesday

In cases of an emergency, you should call 911 for emergency transportation and go to the closest emergency room.

I. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

I1. Care when you have a medical emergency

Definition of a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
    - there is not enough time to safely transfer you to another hospital before delivery.
    - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Call Member Services or your Care Manager at 1-844-812-6896 (TTY 711), 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays, you may be asked to leave a message. Your call will be returned within the next business day.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4, Section D.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What to do if you have a behavioral health emergency

If you have a behavioral health issue or crisis, call the Behavioral Health Crisis Line at 1-401-443- 5995 24 hours a day, 7 days a week. This call is free. We have free interpreter services for people who do not speak English. TTY members call 711. This call is free.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the provider say it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the provider says it was not an emergency, we will cover your additional care only if:

- you use a network provider, **or**
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

I2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

- you get this care from a network provider, **and**
- you follow the other rules described in this chapter.

However, if it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

To access urgently needed services, you should go to the nearest urgent care center that is open. If you are seeking urgent care in our service area, you should look in the Provider and Pharmacy Directory for a listing of the urgent care centers in our plan's network.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Our plan does not cover urgently needed care or any other emergency or non-emergency care that you get outside the United States.

I3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Neighborhood INTEGRITY.

Please visit our website for information on how to obtain needed care during a declared disaster: www.nhpri.org/INTEGRITY.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

J. What to do if you are billed directly for services covered by our plan

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If you have paid for your covered services or if you have gotten a bill for covered medical services, refer to Chapter 7 to learn what to do.

J1. What to do if services are not covered by our plan

Neighborhood INTEGRITY covers all services:

- that are medically necessary, **and**
- that are listed in the plan's Benefits Chart (refer to Chapter 4), **and**
- that you get by following plan rules.

If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

K. Coverage of health care services when you are in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors and other providers test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or get approval from us or your primary care provider. The providers that give you care as part of the study do **not** need to be network providers. This does not include benefits the plan provides that require a clinical trial in order to receive the benefit. Please contact our plan at the number below for additional information.

We encourage you to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your care manager should contact Member Services to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

If you are part of a study that Medicare has **not approved**, you will have to pay any costs for being in the study.

K3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

L. How your health care services are covered when you get care in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. Getting care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is any care that is not voluntary and is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following applies:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

Inpatient hospital coverage is based on medical necessity and requires prior authorization. For more information on inpatient hospital coverage see the Benefits Chart in Chapter 4.

M. Durable medical equipment (DME)

M1. DME as a Member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a Member of Neighborhood INTEGRITY, you usually will not own DME, no matter how long you rent it.

In certain limited situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

Even if you had the DME for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.

M2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2024* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the item.
- There are no exceptions to this when you return to Original Medicare or a Medicare Advantage plan.

M3. Oxygen equipment benefits as a Member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a Member of our plan, we will cover the following:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Neighborhood INTEGRITY covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook.*

Table of Contents

A. Your covered services

This chapter tells you what services Neighborhood INTEGRITY pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services.

If you get or become eligible for long-term services and supports (LTSS), you may be required to pay part of the cost of these services. This is known as "cost-share," and the amount is determined by Rhode Island Medicaid. If you are not getting or are not eligible to get LTSS, you pay nothing for your covered services as long as you follow the plan's rules. Refer to Chapter 3 for details about the plan's rules.

If you need help understanding what services are covered, call your Care Manager and/or Member Services at 1-844-812-6896, 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and holidays, you may be asked to leave a message. Your call will be returned within the next business day.

B. Rules against providers charging you for services

We do not allow Neighborhood INTEGRITY providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to Chapter 7 or call Member Services. The only exception to this is if you are getting LTSS and Rhode Island Medicaid says that you have to pay part of the cost of these services.

C. Our plan's Benefits Chart

The Benefits Chart in Section D tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only when the following rules are met. Unless you are getting or are eligible for long-term services and supports (LTSS), you do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below. If you get or become eligible for LTSS, you may be required to pay part of the cost of these services. This is known as "cost-share," and the amount is determined by Rhode Island Medicaid.

- Your Medicare and Rhode Island Medicaid covered services must be provided according to the rules set by Medicare and Rhode Island Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need medical, surgical, or other services to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary includes services to prevent a health-related condition from getting worse.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Covered services that need PA are marked in the Benefits Chart by an asterisk (*).
- You will find this apple 🍎 next to preventive services in the Benefits Chart.

D. The Benefits Chart

Services that our plan pays for		What you must pay
	Abdominal aortic aneurysm screening The plan will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Abortion* The plan will not pay for an abortion except in cases of rape or incest or if the pregnancy threatens the life of the mother. ***Prior authorization is required.**	$0
	Acupuncture for chronic low back pain* The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. ***Prior authorization is required.**	$0

Services that our plan pays for		What you must pay
	Adult Day Services* The plan will pay for adult day services. The plan covers two levels of adult day services: basic level of service and enhanced level of service. Some examples of adult day services are: • Social and recreational activities • Meals • Nursing or wound care ***Prior authorization may be required.**	$0
	**Alcohol misuse screening and counseling** The plan will pay for alcohol-misuse screening. If you screen positive for alcohol misuse, the plan covers counseling sessions with a qualified provider or practitioner.	$0

Services that our plan pays for		What you must pay
	Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are not emergencies, the plan may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. ***Prior authorization may be required for non-emergency Medicare services.**	$0
	**Annual wellness visit** The plan will pay for an annual checkup once every 12 months. This is to make or update a prevention plan based on your current risk factors.	$0
	**Bone mass measurement** The plan will pay for certain procedures for Members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will also pay for a provider to look at and comment on the results. This service is limited to one (1) every twenty-four (24) months.	$0

Services that our plan pays for		What you must pay
	Breast cancer screening (mammograms) The plan will pay for mammograms and clinical breast exams. This service is limited to one (1) every twelve (12) months.	$0
	Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a provider's order. The plan also covers intensive cardiac rehabilitation programs, which are more intense than standard cardiac rehabilitation programs.	$0
	Cardiovascular (heart) disease risk reduction visits (therapy for heart disease) The plan pays for visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may: • discuss aspirin use, • check your blood pressure, **or** • give you tips to make sure you are eating well.	$0
	Cardiovascular (heart) disease testing The plan pays for blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease. This service is limited to one (1) every sixty (60) months.	$0

Services that our plan pays for		What you must pay
	Care plan alternative therapies* The plan will pay for services that your Care Team has identified in your individual care plan. Some examples of these services are: • acupuncture • chiropractic services • homemaker services • massage therapy • meals brought to your home • meditation classes • personal emergency response system (PERS) • yoga ***Prior authorization may be required.**	$0
	Cervical and vaginal cancer screening The plan will pay for pap tests and pelvic exams. This service is limited to one (1) every twelve (12) months.	$0
	Chiropractic services* The plan will pay for the following services: • adjustments of the spine to correct alignment ***Prior authorization is required.**	$0

Services that our plan pays for		What you must pay
	**Colorectal cancer screening** The plan will pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	$0

Services that our plan pays for		What you must pay
	Counseling to stop smoking or tobacco use If you use tobacco, the plan will pay for face-to-face counseling to help you stop smoking or using tobacco. The plan will also pay for telephone counseling and support.	$0
	Depression screening The plan will pay for depression screening. The screening must be done in a primary care setting that can give follow-up treatment and referrals. This service is limited to one (1) screening every twelve (12) months.	$0
	Diabetes screening The plan will pay for diabetes screening (includes fasting glucose tests). This service is limited to one (1) every twelve (12) months. For members diagnosed with pre-diabetes, this service is covered every six (6) months.	$0

Services that our plan pays for		What you must pay
	**Diabetic self-management training, services, and supplies*** The plan will pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ○ a blood glucose monitor ○ blood glucose test strips Insulin dependent or gestational diabetes members: ➢ Limited to one hundred (100) test strips every thirty (30) days when received from a durable medical equipment (DME) vendor ➢ Limited to one hundred (100) test strips every twenty-five (25) days when received at a pharmacy Non-insulin dependent members: ➢ Limited to one hundred (100) test strips every ninety (90) days when received from a durable medical equipment (DME) vendor ➢ Limited to one hundred (100) test strips every ninety (90) days when received at a pharmacy ○ lancet devices and lancets ○ glucose-control solutions for checking the accuracy of test strips and monitors **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay

	Diabetic self-management training, services, and supplies* (continued)
	• For people with diabetes who have severe diabetic foot disease, the plan will pay for the following:
	  ○ One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or**
	  ○ One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)
	The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes.
	• The plan will pay for training to help you manage your diabetes, in some cases.
	There may be limitations on the brands and manufacturers for supplies when filled at a pharmacy.
	***Authorization is required for non-preferred test strips at a pharmacy. Prior authorization may be required for other services and supplies.**
		$0

Services that our plan pays for		What you must pay
	Doula Services Prenatal and post-partum is covered for pregnant women and new mothers. The following are examples of doula services covered: • services to support pregnant mothers, improve birth outcomes and support new mothers • advocating for and supporting breastfeeding and infant care • provide resources, education, care, and emotional support for the member after pregnancy ends • support for the member and family during the post-partum recovery Other services may be covered. The plan will pay for six (6) visits per pregnancy for prenatal and post-partum care and one (1) labor and delivery visit.	$0

Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies* (For a definition of "Durable medical equipment (DME)," refer to Chapter 12 as well as Chapter 3, Section M of this handbook.) The following are examples of DME items that are covered: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps • speech generating devices • oxygen equipment and supplies • nebulizers • walkers Other items may be covered. With this Member Handbook, we sent you the Neighborhood INTEGRITY list of DME. The list tells you the brands and makers of DME that we will pay for. This most recent list of brands, makers, and suppliers is also available on our website at www.nhpri.org/INTEGRITY. **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies* (continued) Generally, Neighborhood INTEGRITY covers any (DME) covered by Medicare and Rhode Island Medicaid from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to Neighborhood INTEGRITY and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your provider to decide what brand is medically right for you after this 90-day period. (If you disagree with your provider, you can ask them to refer you for a second opinion.) If you (or your provider) do not agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you do not agree with your provider's decision about what product or brand is right for your medical condition. (For more information about appeals, refer to Chapter 9.) ***Prior authorization and quantity limits may be required.**	$0

Services that our plan pays for		What you must pay

	Emergency care
	Emergency care means services that are:
	• given by a provider trained to give emergency services, **and**
	• needed to treat a medical emergency.
	A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	• serious risk to your health or to that of your unborn child; **or**
	• serious harm to bodily functions; **or**
	• serious dysfunction of any bodily organ or part; **or**
	• in the case of a pregnant woman in active labor, when:
	  ○ there is not enough time to safely transfer you to another hospital before delivery.
	  ○ a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	The plan will pay for emergency care and emergency transportation services.
	Coverage is limited to the U.S. and its territories only.
		$0
		If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.

Services that our plan pays for		What you must pay
	Environmental or home modifications* The plan will pay for changes to your home or vehicle to help you live safely at home. The following are examples of services that are covered: • grab bars • shower chairs • eating utensils • raised toilet seats • wheelchair ramps • standing poles Other services may also be covered. ***Prior authorization is required.**	$0

Services that our plan pays for		What you must pay
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – to get certain family planning services from. This means you can get family planning services from any network or out-of-network provider, clinic, hospital, pharmacy or family planning office. The plan will pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (birth control pills, patch, ring, IUD, injections, implants) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility, and related services • counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • treatment for sexually transmitted infections (STIs) • voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • genetic counseling **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Family planning services (continued) The plan will also pay for some other family planning services. However, you must use a provider in the plan's network for the following services: • treatment for AIDS and other HIV-related conditions, including medical case management for people living with HIV/AIDS and non-medical care management services for people living with HIV/AIDS or are at risk for HIV • genetic testing	$0
	Fitness Benefit* Fitness benefit includes a health club membership at eligible YMCA locations and an activity tracker. Eligible YMCA facilities are listed below: • Bayside YMCA (Barrington, RI) • Cranston YMCA (Cranston, RI) • East Side YMCA (Providence, RI) • Kent County YMCA (Warwick, RI) • MacColl YMCA (Lincoln, RI) • Newman YMCA (Seekonk, MA) • Pawtucket Family YMCA (Pawtucket, RI) • South County YMCA (Wakefield, RI) • Woonsocket YMCA (Woonsocket, RI) ***Members must choose one designated location.**	$0

Services that our plan pays for		What you must pay
	**Health and wellness education programs** The plan will pay for disease management and health programs to help you better understand conditions and health concerns. The plan pays for group and individual education programs including nutritional therapy services and weight management programs when delivered by a licensed dietitian. Chronic conditions like asthma, diabetes, and chronic obstructive pulmonary disease (COPD) can be difficult to manage. The plan will also pay for special testing and medications to help keep your condition under control and keep you healthy.	$0
	Healthy Food and Nutrition Benefit Coverage includes a healthy food and savings card with a $35 monthly allowance that can be used to purchase healthy and nutritious groceries.	$0
	Hearing services The plan pays for routine hearing exams and hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. The plan also covers hearing aids and evaluations for fitting hearing aids once every three years.	$0

Services that our plan pays for		What you must pay
	**HIV screening** The plan pays for HIV screening exams and HIV screening tests. The plan will also pay for medical case management for people living with HIV/AIDS and non-medical care management services for people living with HIV/AIDS or who are at risk for HIV. This service is limited to one (1) screening every twelve (12) months. Additional screenings are covered for members that are pregnant.	$0
	Home care services* The plan will pay for personal care services, such as help with dressing and eating, and homemaking services, such as laundry and shopping. Home care services do not include respite care or day care. The plan may also pay for other services not listed here. ***Prior authorization is required.**	$0

Services that our plan pays for		What you must pay
	Home health agency care* Before you can get home health services, a provider must tell us you need them, and they must be provided by a home health agency. The plan will pay for the following services: • full-time, part-time or intermittent skilled nursing, certified nursing assistant, and home health aide services • physical therapy, occupational therapy, and speech therapy ○ The plan will cover a total of 24 outpatient visits for occupational therapy; ○ The plan will cover a total of 24 outpatient visits for physical therapy; ○ The plan will cover a total of 24 outpatient visits for speech therapy. • medical and social services • medical equipment and supplies The plan may also pay for other services not listed here. ***Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0

Services that our plan pays for		What you must pay
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice provider can be a network provider or an out-of-network provider The plan will pay for the following while you are getting hospice services: • drugs to treat symptoms and pain • short-term respite care • home care **Hospice services and services covered by Medicare Part A or B are billed to Medicare.** • Refer to Section E1 of this chapter for more information. **For services covered by Neighborhood INTEGRITY but not covered by Medicare Part A or B:** • Neighborhood INTEGRITY will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Hospice care (continued) For drugs that may be covered by Neighborhood INTEGRITY's Medicare Part D benefit: • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5. **Note:** If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. You may call Member Services at 1-844-812-6896 and 711, 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday.	$0
	Immunizations The plan will pay for the following services: • pneumonia vaccine • flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • other vaccines if you are at risk and they meet Medicare Part B or Rhode Island Medicaid coverage rules The plan will pay for other vaccines that meet the Rhode Island Medicaid or Medicare Part D coverage rules. Read Chapter 6 to learn more.	$0

Services that our plan pays for		What you must pay
	Incontinence supplies* The plan will pay for supplies such as: • Diapers ○ Prior authorization is required when the quantity is between one hundred and ninety-three (193) and three hundred (300) per month. ○ Limited to three hundred (300) per month. • Underpads ○ Limited to one hundred and fifty (150) disposable underpads per month. • Liners ***Prior authorization is required.**	$0
	In-Home Support Services Coverage includes up to 120 hours per year of companion care to assist with everyday tasks.	$0

Services that our plan pays for		What you must pay
	Inpatient hospital care* The plan will pay for medically necessary inpatient hospital care. The plan covers the following services: • semi-private room (or a private room if it is medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests and other diagnostic tests • x-rays and other radiology services, including technician materials and services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance use treatment services • blood, including storage and administration ○ The plan will pay for whole blood, packed red cells and all other parts of blood. • physician services **This benefit is continued on the next page.**	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

Services that our plan pays for		What you must pay
	Inpatient hospital care* (continued) • transplants, including corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. Other types of transplants may be covered. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If Neighborhood INTEGRITY provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. ***Prior authorization is required.**	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.
	Inpatient services in a psychiatric hospital* • The plan will pay for mental health care services that require a hospital stay. ***Prior authorization is required.**	$0

Services that our plan pays for		What you must pay

	Kidney disease services and supplies
	The plan will pay for the following services:
	• kidney disease education services to teach kidney care and help Members make good decisions about their care.
	  ○ you must have stage IV chronic kidney disease, and your provider must refer you
	  ○ the plan will cover up to six sessions of kidney disease education service
	• outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible
	• inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care
	• self-dialysis training, including training for you and anyone helping you with your home dialysis treatments
	• home dialysis equipment and supplies
	• certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply
	Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart.
		$0

Services that our plan pays for		What you must pay
	**Lung cancer screening** The plan will pay for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least (1) pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0
	Meals The plan will pay for home-delivered meals after discharge from an inpatient hospitalization or surgery. This benefit covers fourteen (14) meals for two (2) weeks and is limited twice (2) per year.	$0
	**Medicare Diabetes Prevention Program (MDPP)** The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs* These drugs are covered under Part B of Medicare. Neighborhood INTEGRITY will pay for the following drugs: • drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • clotting factors you give yourself by injection if you have hemophilia • osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a provider certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • antigens • certain oral anti-cancer drugs and anti-nausea drugs **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued)* • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases • We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 explains what you pay for your outpatient prescription drugs through our plan. *Authorization may apply to some services in this category, including but not limited to, provider-administered drugs prescribed to treat cancer, immune deficiencies, rare diseases, neuromuscular disorders, asthma, osteoarthritis, and osteoporosis. **Step therapy may be required for the following Part B prescription drug categories: • Hemophilia Clotting factors • Autoimmune/Chronic Inflammatory disease drugs • Oncology and hematology drugs • Anti-emetics **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued)* • Anti-Gout drugs • Immune Globulins (IVIG and SCIG) • Multiple Sclerosis (MS) agents • Retina Disease drugs • Monoclonal antibodies • Long acting colony stimulating factors • Short acting colony stimulating factors • Enzyme Replacement Therapies • Hyaluronic acids • Anti-Asthmatic drugs • Endocrine and metabolic agents • Androgens • Bacterial collagenase enzyme • Duchene Muscular Dystrophy agents • Imidazole-related antifungals • Corticotropin • Hereditary Angioedema (HAE) drugs • Systemic lupus erythematosus (SLE) agents • Passive immunizing and treatment agents monoclonal antibodies • Amyloidosis-associated polyneuropathy drugs • ALS agents • Acromegaly drugs **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued)* • Cryopyrin-associated periodic syndrome drugs Organ drugs • Pulmonary arterial hypertension (PAH) drugs • Erythropoiesis stimulating agents (ESA) • Migraine therapy drugs • Depression/PDD drugs • Spinal Muscular Atrophy (SMA) drugs • Botulinum toxins ***Prior authorization is required**	$0

Services that our plan pays for		What you must pay
	Nursing facility care* The plan will pay for the following services: • a semi private room, or a private room if it is medically needed • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood clotting factors • blood, including storage and administration ○ the plan will pay for whole blood, packed red, and all other parts of blood, including storage and administration, beginning with the first pint. • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • x-rays and other radiology services given by nursing facilities • physician/provider services **This benefit is continued on the next page.**	$0 If you get nursing facility care, you may have to pay part of the cost of your services. This is known as “cost-share,” and the amount is determined by Rhode Island Medicaid.

Services that our plan pays for		What you must pay
	Nursing facility care* (continued) The plan will also pay for other services not listed here. You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse lives at the time you leave the hospital. ***Prior authorization is required.**	$0 If you get nursing facility care, you may have to pay part of the cost of your services. This is known as "cost-share," and the amount is determined by Rhode Island Medicaid.
	Nutritional/dietary benefit The plan will pay for medical nutrition therapy and counseling delivered by a licensed dietician to help you manage a chronic condition or medical problem such as diabetes, high blood pressure, obesity, or cancer. The plan will also pay for medical nutrition therapy and counseling if you are taking a medication that can affect your body's ability to absorb nutrients or your metabolism.	$0
	**Obesity screening and therapy to keep weight down** The plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. This service is limited to twenty-two (22) visits every twelve (12) months.	$0

Services that our plan pays for		What you must pay
	Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0

Services that our plan pays for		What you must pay
	Outpatient diagnostic tests and therapeutic services and supplies* The plan will pay for the following services: • x-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood and blood storage and administration • other outpatient diagnostic tests • genetic testing not used for diagnosis of pregnancy ○ Prior authorization is required • T-Cell (CAR-T) therapy ○ Prior authorization is required • IgE (allergy) testing ○ Prior authorization is required when more than fifteen (15) units of testing is received per twelve (12) rolling months • Cystic Fibrosis testing ○ Limited to one (1) test per lifetime The plan may also pay for other services not listed here. ***Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Outpatient hospital services* The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will pay for the following services: ○ services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ▪ Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient." ▪ Sometimes you can be in the hospital overnight and still be an "outpatient." ▪ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101 • labs and diagnostic tests billed by the hospital • mental health care, including care in a partial-hospitalization program, if a provider certifies that inpatient treatment would be needed without it • x-rays and other radiology services billed by the hospital • medical supplies, such as splints and casts • preventive screenings and services listed throughout the Benefits Chart • some drugs that you can't give yourself The plan may also pay for other services not listed here. ***Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Outpatient mental health care* The plan will pay for mental health services provided by: • community mental health centers, • a state-licensed psychiatrist or doctor, • a clinical psychologist, • a clinical social worker, • a clinical nurse specialist, • a licensed professional counselor (LPC), • a licensed marriage and family therapist (LMFT), • a nurse practitioner (NP), • a physician assistant (PA), **or** • any other Medicare- or Rhode Island Medicaid-qualified mental health care professional as allowed under applicable state laws. The plan will pay for the following: • clinic services • individual, group, and family treatment • crisis intervention and stabilization emergency services • diagnostic evaluation • psychological testing • medication evaluation and management **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Outpatient mental health care* (continued) • specialized services for people with serious mental illness, including Integrated Health Home and Assertive Community Treatment • day/evening treatment • clubhouse • integrated dual diagnosis treatment for people with mental illness and substance use disorders • court-ordered mental health treatment • partial hospitalization Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. • intensive outpatient treatment Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. The plan may also pay for other services not listed here. ***Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Outpatient rehabilitation services The plan will pay for physical therapy, occupational therapy, speech therapy, language therapy, hearing therapy, and respiratory therapy. • The plan will cover a total of 24 outpatient visits for physical therapy. • The plan will cover a total of 24 outpatient visits for occupational therapy. • The plan will cover a total of 24 outpatient visits for speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0

Services that our plan pays for		What you must pay
	Outpatient substance use treatment services* The plan will pay for: • substance use counseling • medication-assisted opioid treatment programs, including methadone dosing and counseling and prescriptions for other medications such as Suboxone® • opioid Treatment Program (OTP) Health Home services, which provide resources to opioid dependent Members who are currently getting or who meet criteria for medication-assisted treatment • medically managed detoxification in a hospital setting or a detoxification program • integrated dual diagnosis treatment for people with mental illness and substance use disorders • court-ordered substance use treatment The plan may also pay for other services not listed here. ***Prior authorization may be required.**	$0
	Outpatient surgery* The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. ***Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits* The plan will pay for the following services: ○ Medically necessary health care or surgery services given in places such as: ○ physician's office ○ certified ambulatory surgical center ○ hospital outpatient department ○ Consultation, diagnosis, and treatment by a specialist ○ Basic hearing and balance exams given by your primary care provider, if your provider orders them to find out whether you need treatment ○ Certain additional telehealth services, including those for: ○ Primary Care Physician Services ○ Physician Specialist Services ○ Individual Sessions for Mental Health Specialty Services ○ Group Sessions for Mental Health Specialty Services ○ Other Health Care Professional ○ Individual Sessions for Psychiatric Services ○ Group Sessions for Psychiatric Services **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay

	Physician/provider services, including doctor's office visits* (continued)
	• Certain Additional Telehealth Services:
	  ○ Individual Sessions for Outpatient Substance Abuse
	  ○ Group Sessions for Outpatient Substance Abuse
	  ○ Kidney Disease Education Services
	  ○ Diabetes Self-Management Training
	  ○ Other Medicare-covered Preventive Services.
	• You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.
	• Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
	• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke
	• Telehealth services for members with a substance use disorder or co-occurring mental health disorder
	This benefit is continued on the next page.
		$0

Services that our plan pays for		What you must pay

	Physician/provider services, including doctor's office visits* (continued)
	• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
	  ○ you have an in-person visit within 6 months prior to your first telehealth visit
	  ○ you have an in-person visit every 12 months while receiving these telehealth services
	  ○ exceptions can be made to the above for certain circumstances
	• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
	• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:
	  ○ you're not a new patient and
	  ○ the check-in isn't related to an office visit in the past 7 days and
	  ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
	This benefit is continued on the next page.
		$0

Services that our plan pays for		What you must pay

	Physician/provider services, including doctor's office visits* (continued)
	• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if:
	  ○ you're not a new patient and
	  ○ the evaluation isn't related to an office visit in the past 7 days and
	  ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
	• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient
	• Second opinion by another network provider before surgery
	• Non-routine dental and oral health care, including operating room charges and anesthesia services. Covered services are limited to:
	  ○ surgery of the jaw or related structures,
	  ○ setting fractures of the jaw or facial bones,
	  ○ pulling teeth before radiation treatments of neoplastic cancer, **or**
	  ○ services that would be covered when provided by a physician.
	***Prior authorization may be required.**
		$0

Services that our plan pays for		What you must pay
	Podiatry services The plan will pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for Members with conditions affecting the legs, such as diabetes	$0
	**Prostate cancer screening exams** The plan will pay for the following services: • a digital rectal exam • a prostate specific antigen (PSA) test This service is limited to one (1) screening per twelve (12) months for members age 50 and older.	$0

Services that our plan pays for		What you must pay
	Prosthetic devices and related supplies* Prosthetic devices replace all or part of a body part or function. The plan will pay for the following prosthetic devices: • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) The plan will pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. Refer to “Vision Care” later in this section for details. The plan will not pay for prosthetic dental devices. The plan may pay for other devices not listed here. ***Prior authorization may be required.**	$0
	Pulmonary rehabilitation services The plan will pay for pulmonary rehabilitation programs for Members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The Member must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0

Services that our plan pays for		What you must pay
	Residential mental health and substance use treatment services* The plan will pay for: • short- and long-term mental health treatment residential services. • acute substance use residential treatment • court-ordered mental health and substance use treatment ***Prior authorization may be required.**	$0
	**Routine Dental Care*** The plan covers preventive dental services up to a maximum of $1,000 per year. Covered services include: • two (2) cleanings • one (1) routine oral exam • one (1) fluoride treatment • dental X-rays • fillings and denture repairs ***Other limitations may apply.**	$0

Services that our plan pays for		What you must pay
	Services to prevent a hospital or nursing facility admission* The plan will pay for a limited set of services for people at high risk for a hospitalization or a nursing facility admission, including: • homemaker services, such as meal preparation or routine household care • minor changes to your home, such as grab bars, shower chairs, and raised toilet seats • physical therapy services prior to surgery if the therapy will enhance recovery or reduce rehabilitation time • physical therapy evaluation for home accessibility appliances or devices ***Prior authorization may be required.**	$0
	**Sexually transmitted infections (STIs) screening and counseling** The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. A primary care provider must order the tests. The plan will also pay for face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. High-intensity behavioral health counselling sessions are limited to two (2) sessions annually.	$0

Services that our plan pays for		What you must pay
	Skilled nursing facility (SNF) care* The plan will pay for the following services: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration ○ The plan will pay for whole blood, packed red, and all other parts of blood, including storage and administration, beginning with the first pint. • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • x-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services **This benefit is continued on the next page.**	$0

Services that our plan pays for		What you must pay
	Skilled nursing facility (SNF) care* (continued) The plan may also pay for other services not listed here. You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital ***Prior authorization is required.**	$0
	Special medical equipment/minor assistive devices* The plan will pay for special medical equipment and supplies to make it easier for you to do daily activities, such as eating and bathing. ***Prior authorization may be required for some equipment and devices.**	$0

Services that our plan pays for		What you must pay
	Supervised exercise therapy (SET) The plan will pay for SET for Members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in Members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0

Services that our plan pays for		What you must pay
	Urgently needed care* Urgently needed care is non-emergency care given to treat: • a sudden medical illness, **or** • an acute injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider because given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). ***Coverage is limited to the U.S. and its territories.**	$0

Services that our plan pays for		What you must pay
	**Vision care*** The plan will pay for a routine eye exam and eyeglasses once every two years. Eyeglass lenses are covered more than once every two years only if it is medically necessary. Contact lenses may be covered if you have a visual or ocular condition that is better treated with contact lenses than with eyeglasses. The plan will pay for outpatient doctor and other provider services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan will pay glaucoma screenings. People at high risk of glaucoma include: • people with a family history of glaucoma, • people with diabetes, • African-Americans who are age 50 and older, **and** • Hispanic Americans who are 65 or older. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) Glaucoma screenings are limited to one (1) per twelve (12) months. ***Prior authorization may be required.**	$0

Services that our plan pays for		What you must pay
	**"Welcome to Medicare" Preventive Visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your provider's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

Our plan also covers long-term services and supports (LTSS) for Members who need them and qualify for LTSS through Rhode Island Medicaid. You may need to pay for part of the cost of the services. This is called “cost-share,” and the amount you pay is determined by Rhode Island Medicaid.

LTSS Services	What you must pay
Assisted living* The plan will pay for services and supports for you to live in an assisted living facility. The plan covers multiple levels of assisted living based on your medical needs. ***Prior authorization is required.**	Determined by Rhode Island Medicaid
Community transition services The plan will provide services to help you move from a nursing facility or institution to a private home. The plan will also pay for some one-time living expenses to help you set up a private home when you move from a nursing facility or institution.	Determined by Rhode Island Medicaid
Day supports The plan will pay for services to help you with self-help and social skills.	Determined by Rhode Island Medicaid
Employment supports The plan will pay for services, such as supervision, transportation, or training, to help you get or keep a paid job.	Determined by Rhode Island Medicaid
Homemaker* The plan will pay for homemaker services to help with general householder tasks, such as meal preparation or general household care. ***Prior authorization is required.**	Determined by Rhode Island Medicaid
Home Delivered Meals The plan will pay for up to one meal five days per week to be delivered to your home.	Determined by Rhode Island Medicaid

LTSS Services	What you must pay
Personal care assistance* The plan will pay for assistance with daily activities in your home or the community if you have a disability and are unable to do the activities on your own. ***Prior authorization is required.**	Determined by Rhode Island Medicaid
Private duty nursing The plan will pay for individual and continuous care provided by licensed nurses in your home.	Determined by Rhode Island Medicaid
Rehabilitation services* The plan will pay for specialized physical, occupational, and speech therapy services at outpatient rehabilitation centers. ➢ The plan will cover a total of 24 outpatient visits for physical therapy. ➢ The plan will cover a total of 24 outpatient visits for occupational therapy. ➢ The plan will cover a total of 24 outpatient visits for speech therapy. ***Prior authorization may be required.**	Determined by Rhode Island Medicaid
Residential supports The plan will pay for services to help you with daily activities to live in your own home, such as learning how to prepare meals and do household chores.	Determined by Rhode Island Medicaid
Respite The plan will pay for short-term or temporary caregiving services when a person who usually cares for you is not available to provide care.	Determined by Rhode Island Medicaid
RIte @ Home (Supported Living Arrangements – Shared Living) The plan will pay for personal care and other services provided by a caretaker who lives in the home.	Determined by Rhode Island Medicaid

LTSS Services	What you must pay
Self-directed services and supports If you are enrolled in self-directed care, the plan will pay for: • services, equipment, and supplies that help you live in the community • services to help you direct and pay for your own services	Determined by Rhode Island Medicaid
Senior/adult companion The plan will pay for non-medical help and social support with daily activities, such as meal preparation, laundry, and shopping.	Determined by Rhode Island Medicaid
Skilled nursing services* The plan will pay for skilled nursing services. ***Prior authorization may be required.**	Determined by Rhode Island Medicaid

E. Benefits covered outside of Neighborhood INTEGRITY

The following services are not covered by Neighborhood INTEGRITY but are available through Medicare or Rhode Island Medicaid.

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice provider can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Neighborhood INTEGRITY pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis:

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by Neighborhood INTEGRITY's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5.

Note: If you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. You can call Member Services at 1-844-812-6896 and 711, 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

E2. Dental services

Regular dental care, such as cleanings, fillings or dentures, are covered by Rhode Island Medicaid. **For regular dental care, find a provider that accepts Rhode Island Medicaid and use your Rhode Island Medicaid ("anchor") ID card.** In some cases, dental care required to treat illness or injury may be covered by the plan as inpatient or outpatient care. Call Neighborhood INTEGRITY at 1-844-812-6896 (TTY 711) if you are not sure whether the plan or Rhode Island Medicaid covers the dental services you need or if you need help finding a dentist.

E3. Non-emergency transportation

You may be eligible for a reduced-fare RIPTA bus pass. To get a reduced-fare RIPTA bus pass, visit the RIPTA Identification Office at One Kennedy Plaza, Providence, RI 02903 or the RIPTA Customer Service Office at 705 Elmwood Avenue, Providence, RI 02907. Call RIPTA at 1-401-784-9500 (TTY 1-800-745-5555) for more information, or visit www.ripta.com/reducedfareprogram.

If you are unable to use a RIPTA bus pass, Rhode Island Medicaid covers non-emergency medical transportation (NEMT) services for rides to medical, dental, or other health-related appointments. If you need routine NEMT, call 1-855-330-9131 (TTY 711), 5:00 am – 6:00 pm, Monday – Friday, or Neighborhood INTEGRITY at 1-844-812-6896 (TTY 711).**When scheduling NEMT, use your Rhode Island Medicaid ("anchor") ID card.** You may also schedule routine NEMT through the online member portal at www.mtm-inc.net/rhode-island/.

You may ask for urgent care transportation 24 hours a day, 7 days a week. Schedule transportation for non-urgent care **at least** 48 hours before your appointment.

Call to schedule on:	If you need a ride on:
Monday	Wednesday
Tuesday	Thursday
Wednesday	Friday, Saturday, or Sunday
Thursday	Monday
Friday	Tuesday

E4. Residential services for people with intellectual and developmental disabilities

Residential services for people with intellectual and developmental disabilities are covered by Rhode Island Medicaid. Call Neighborhood INTEGRITY at 1-844-812-6896 (TTY 711) if you are unsure whether the services you need are covered by the plan or Rhode Island Medicaid.

E5. Home stabilization services

If you are homeless, at risk for becoming homeless, or moving from a nursing facility to the community, you may be able to get services from Rhode Island Medicaid to help you with housing-related problems. If you have questions about the services that Rhode Island Medicaid covers or if you would like a referral to this program, call Neighborhood INTEGRITY at 1-844-812-6896 (TTY 711).

F. Benefits not covered by Neighborhood INTEGRITY, Medicare, or Rhode Island Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not pay for these benefits. Medicare and Rhode Island Medicaid will not pay for them either.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan:**

- Services considered not “reasonable and necessary,” according to the standards of Medicare and Rhode Island Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically necessary, and Medicare or Rhode Island Medicaid pays for it.
- A private room in a hospital, except when it is medically necessary.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Fees charged by your spouse or domestic partner, guardian, or legal representative.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.

- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Radial keratotomy, LASIK surgery, and other low-vision aids.
- Reversal of sterilization procedures, and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and there is VA cost sharing, we will reimburse the veteran for the amount they paid.

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Neighborhood INTEGRITY also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in Chapter 4.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.

2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.

3. You generally must use a network pharmacy to fill your prescription.

4. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.
- Refer to page 180 to learn about asking for an exception.

5. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. "Medically- accepted indication" is defined as a diagnosis that was approved under the Federal Food, Drug, and Cosmetic Act, or that is supported through scientific research

found in the American Hospital Formulary Service Drug Information and/or DRUGDEX® Information System.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions **only** if they are filled at the plan's network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan Members. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug.

If you do not have your Member ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to pay you back. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

- To learn how to ask us to pay you back, refer to Chapter 7.
- If you need help getting a prescription filled, you can contact Member Services.

A3. What to do if you want to change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, you can contact Member Services.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A5. Using a specialized pharmacy

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
    - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order up to a 90-day supply. A 90-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail:

- Visit the mail-order website and register online at www.caremark.com/mailservice
- Or, call Member Services.

Usually, a mail-order prescription will get to you within 7-10 business days. If your mail-order prescription is delayed, and you need an emergency supply from a retail pharmacy, call Member Services for help with an override request.

Mail-order processes

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. New prescriptions the pharmacy gets from you

The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. New prescriptions the pharmacy gets directly from your provider's office

The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by calling 1-844-268-1908.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 1-844-268-1908.

If you have never used our mail order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before it is shipped.
- It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you got directly from your health care provider's office, please contact us by calling 1-844-268-1908.

3. Refills on mail-order prescriptions

For refills, please contact your pharmacy 15 days before your current prescription will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You can update this information by calling 1-844-268-1908 or by visiting www.caremark.com.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to the section above to learn about mail-order services.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a Member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- A Federal Emergency Management Agency (FEMA) declared emergency
- Treatment of an illness while travelling outside of the plan's service area, but within the United States, where there is no network pharmacy.

In these cases, please check first with Member Services to find out if there is a network pharmacy nearby.

A9. Paying you back if you pay for a prescription

If you must use an out-of-network pharmacy, you will generally have to pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to Chapter 7.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

If we cover a drug only for some medical conditions, it is clearly identified on our Drug List and in Medicare Plan Finder along with the specific medical conditions that are covered.

B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs and items covered under your Medicaid benefits.

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product such as a vaccine or insulin.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs or biological products and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Visit the plan's website at www.nhpri.org/INTEGRITY. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at www.caremark.com or call Member Services. With this tool you can search for drugs on the Drug List and if there are alternative drugs on the Drug List that could treat the same condition.

B3. Drugs that are not on the Drug List

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Neighborhood INTEGRITY will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Neighborhood INTEGRITY for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your provider might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- drugs used to promote fertility
- drugs used for cosmetic purposes or to promote hair growth
- drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List tiers

Every drug on the plan's Drug List is in one of 3 tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

- Tier 1 includes generic drugs
- Tier 2 includes brand drugs
- Tier 3 includes non-Medicare prescription drugs and over-the-counter (OTC) drugs

To find out which tier your drug is in, look for the drug in the plan's Drug List.

Chapter 6 tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plan expects your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9.

1. Limiting use of a brand name drug or original biological products when a generic or interchangeable biosimilar version is available

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological products and usually costs less. In most cases, if there is a generic or interchangeable biosimilar version of a brand name drug or original biological product, our network pharmacies will give you the generic or interchangeable biosimilar version.

- We usually will not pay for the brand name drug or original biological product when there is a generic version.
- However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar will not work for you ***or*** has written "No substitutions" on your prescription for a brand name drug or original biological product ***or*** has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your provider must get approval from Neighborhood INTEGRITY before you fill your prescription. If you don't get approval, Neighborhood INTEGRITY may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at www.nhpri.org/INTEGRITY.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- The drug you want to take is not covered by the plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- The drug is covered, but there are special rules or limits on coverage for that drug. As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you have been taking:
   - is no longer on the plan's Drug List, **or**
   - was never on the plan's Drug List, **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in the plan last year.
     - We will cover a temporary supply of your drug **during the first 90 days of the calendar year** if your drug is no longer on the plan's Drug List or is now limited in some way.
     - This temporary supply will be for up to:
       - A 30-day supply if you **do not** live in a long-term care facility
       - A 31-day supply if you do live in a long-term care facility

- If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You are new to the plan.
  - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan**.
  - This temporary supply will be for up to:
    - A 30-day supply if you **do not** live in a long-term care facility
    - A 31-day supply if you do live in a long-term care facility, and
    - A 90-day supply for Medicaid-covered drugs.
  - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of a Part D drug or 90-day supply of a Medicaid-covered drug. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
  - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
  - If your level of care changes then we will cover at least one 31-day supply
  - To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- You can change to another drug.

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- You can ask for an exception.

You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9.

If you need help asking for an exception, you can contact Member Services.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but Neighborhood INTEGRITY may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval (PA) for a drug. (PA is permission from Neighborhood INTEGRITY before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless**:**

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check Neighborhood INTEGRITY's up to date Drug List online at www.nhpri.org/INTEGRITY **or**
- Call Member Services to check the current Drug List at 1-844-812-6896.

Some changes to the Drug List will happen **immediately**. For example:

- A new generic drug becomes available. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.

  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead or
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9.

We may make changes that do not affect the drugs you take now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a copay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

F2. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require certain drugs (e.g., a pain medication, anti-nausea drugs, laxative, or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4.

G. Programs on drug safety and managing drugs

G1. Programs to help Members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors, or drugs that:

- may not be needed because you are taking another drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

G2. Programs to help Members manage their drugs

If you take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your provider about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to Members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact Member Services.

G3. Drug management program to help Members safely use their opioid medications

Neighborhood INTEGRITY has a program that can help Members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility

G4. Programs to help Members safely dispose of unused prescription drugs and controlled substances

It is important to get rid of any unused prescription drugs in your home. You can:

- bring them to a drug disposal box or take-back event
- dispose of needles safely at ENCORE Needle Exchange
    - visit 557 Broad Street, Providence, RI, 02907
    - Call 1-401-781-0665 for more information

Most prescription painkillers are controlled substances and can be addictive under some circumstances, especially if not used correctly. To get rid of prescription painkillers, make sure the drug disposal location accepts controlled substances. For more information, speak with your local pharmacist or visit www.preventoverdoseri.org/get-rid-of-meds/.

Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, **and**
- drugs and items covered under Rhode Island Medicaid, **and**
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Medicaid, you are getting "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

To learn more about prescription drugs, you can look in these places:

- The plan's *List of Covered Drugs.*
  - We call this the "Drug List." It tells you:
    - Which drugs the plan pays for
    - Which of the 3 tiers each drug is in
    - Whether there are any limits on the drugs
  - If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at www.nhpri.org/INTEGRITY. The Drug List on the website is always the most current.

- Chapter 5 of this *Member Handbook*.
  - Chapter 5 tells how to get your outpatient prescription drugs through the plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs are not covered by our plan.
- The plan's *Provider and Pharmacy Directory.*
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan.
  - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5.
  - You can use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2) and alternatives drugs for a specific condition. You can call Member Services for more information.

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A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs.** This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount the plan pays.

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits.* We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what the plan paid, and what you and others paying for you paid.
- **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you have paid for. You can ask us to pay you back for the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

To learn how to ask us to pay you back for the drug, refer to Chapter 7.

3. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a state pharmaceutical assistance program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. Check the EOBs we send you.

When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, please call Member Services. You have the option to receive your Part D Explanation of Benefits electronically. It provides the same information and in the same format as the paper Explanation of Benefits that you receive today. To begin receiving a paperless Explanation of Benefits, go to www.caremark.com to register. You will receive an e-mail notification when you have a new Explanation of Benefits to view. Be sure to keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With Neighborhood INTEGRITY, you pay nothing for covered drugs as long as you follow the plan's rules.

C1. The plan's tiers

Tiers are groups of drugs on our Drug List. Every drug in the plan's Drug List is in one of 3 tiers. You have no copays for prescription and over-the-counter drugs on Neighborhood INTEGRITY's Drug List. To find the tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs are generic drugs.
- Tier 2 drugs are brand name drugs.
- Tier 3 drugs are non-Medicare prescription and over-the-counter (OTC) drugs.

C2. Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- a network pharmacy, **or**
- an out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5 to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5 in this handbook and the plan's *Provider and Pharmacy Directory.*

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 or the *Provider and Pharmacy Directory.*

C4. What you pay

Your share of the cost when you get a one-month or long-term supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 90-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5 for details.
Cost Sharing **Tier 1** (Generic drugs)	$0	$0	$0	$0
Cost Sharing **Tier 2** (Brand name Drugs)	$0	$0	$0	$0
Cost Sharing **Tier 3** (Non-Medicare prescription drugs and over-the-counter (OTC) drugs)	$0	$0	$0	$0

For information about which pharmacies can give you long-term supplies, refer to the plan's *Provider and Pharmacy Directory.*

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's List of Covered Drugs (Formulary) or contact Member Services for coverage and cost sharing details about specific vaccines.

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.

2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your provider.

D1. What you need to know before your vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with Neighborhood INTEGRITY to ensure that you do not have any upfront costs for a Part D vaccine.

Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for health care or drugs, send the bill to us. To send us a bill, refer to page 132.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid the bill, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.
- If you are getting long-term services and supports, you may have to pay part of the cost of the services. This is called “cost-share,” and the amount is determined by Rhode Island Medicaid.

Contact Member Services if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask our plan to pay you back or to pay a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should ask the provider to bill the plan.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
    - If the provider should be paid, we will pay the provider directly.
    - If you have already paid for the service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill the plan. Show your Neighborhood INTEGRITY Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

- Because Neighborhood INTEGRITY pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem. However, if you are getting long-term services and supports, you may have to pay part of the cost of the services. This is called "cost-share," and the amount is determined by Rhode Island Medicaid.
- If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled

If you use an out-of-network pharmacy, you will have to pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Please refer to Chapter 5 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Member ID Card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
    - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (refer to Chapter 9).
    - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision.

To learn how to make an appeal, refer to Chapter 9.

B. Sending a request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records.** You can ask your care manager for help.

Medical and Durable Medical Equipment (DME) services request for payment

Mail your request for payment together with any bills or receipts to us at this address:

Neighborhood Health Plan of Rhode Island

Attn: Member Services

910 Douglas Pike

Smithfield, RI 02917

Behavioral health services request for payment

Optum®

PO Box 30760

Salt Lake City, UT 84130-0760

Part D prescription drug request for payment

CVS Caremark®

PO BOX 52066

Phoenix, AZ 85072-2066

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (www.nhpri.org/INTEGRITY), or you can call Member Services and ask for the form.

You may also call our plan to ask for payment. Please call Neighborhood INTEGRITY at 1-844-812-6896 and TTY 711, 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and holidays, you may be asked to leave a message. Your call will be returned within the next business day. The call is free.

C. Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay for it. If you have already paid for the service or drug, we will mail you a check for what you paid. If you have not paid for the service or drug yet, we will pay the provider directly.

Chapter 3 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

To learn more about coverage decisions, refer to Chapter 9.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called making an appeal. You can also make an appeal if you do not agree with the amount we pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, refer to Chapter 9.

- If you want to make an appeal about getting paid back for a health care service, refer to page 161.
- If you want to make an appeal about getting paid back for a drug, refer to page 177.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a Member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Your right to get services and information in a way that meets your needs

We must ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio.
- Our plan can also give you materials in Spanish, Portuguese, and Khmer/Cambodian. You can ask to get this document and future materials in your preferred language and/or alternate format by calling Member Services. This is called a "standing request". Member Services will document your standing request in your member record so that you can receive materials now and in the future in your preferred language and/or format. You can change or delete your standing request at any time by calling Member Services.

If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Medicaid 1-855-697-4347 (TTY 711). You may also go to your local DHS office for in-person assistance. Call 1-855-697-4347 (TTY 711) to find the nearest DHS office to you.
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Debemos garantizarle la prestación de **todos** los servicios de una forma culturalmente competente y accesible. Además, debemos informarle sobre los beneficios del plan y sus derechos de manera que pueda entenderlos. Debemos informarle sobre sus derechos cada año mientras esté en nuestro plan.

- Si desea obtener información que pueda entender, llame a Servicios para afiliados. Nuestro plan ofrece servicios gratuitos de interpretación para responder a las preguntas en diferentes idiomas.
- Nuestro plan también puede brindarle materiales en otros idiomas además del inglés y en formatos como letra grande, braille o audio.
- Nuestro plan también puede facilitarle materiales en español, portugués y jemer/camboyano. Puede solicitar que le entreguen este documento y futuros materiales en su idioma preferido o en un formato alternativo llamando a Servicios para afiliados. Esto se denomina "solicitud permanente". Servicios para afiliados registrará su solicitud

permanente en su expediente de afiliado de modo que de ahora en adelante pueda recibir los materiales en el idioma o formato que prefiera. Puede modificar o eliminar la solicitud permanente en cualquier momento llamando a Servicios para afiliados.

Si tiene dificultades para obtener información del plan debido a problemas de idioma o una discapacidad y desea presentar una queja, comuníquese con:

- Medicare llamando al 1-800-MEDICARE (1-800-633-4227). Puede comunicarse las 24 horas del día, los 7 días de la semana. Los usuarios del modo TTY pueden llamar al 1-877-486-2048.
- Medicaid de Rhode Island a través de la Oficina del Departamento de Servicios Humanos (DHS) de Rhode Island llamando al 1-855-697-4347 (TTY 711). También puede acudir a la oficina local del DHS para recibir asistencia en persona. Llame al 1-855-697-4347 (TTY 711) para encontrar la oficina más cercana del DHS.
- la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

Devemos garantir que **todos** os serviços sejam fornecidos a si de maneira culturalmente competente e acessível. Também devemos informá-lo sobre os benefícios do plano e os seus direitos de uma maneira que possa entender. Devemos informá-lo sobre os seus direitos a cada ano que está no nosso plano.

- Para obter informações de uma forma compreensível, ligue para os Serviços dos Membros. o nosso plano tem serviços de intérprete gratuitos disponíveis para responder a perguntas em diferentes idiomas.
- O nosso plano também pode fornecer materiais noutros idiomas além do Inglês e em outros formatos como letras grandes, braille ou áudio.
- O nosso plano também pode fornecer materiais em Espanhol, Português e Khmer/Cambojano. Pode pedir para obter este documento e materiais futuros no seu Idioma preferido e/ou formato alternativo ao ligar para os Serviços dos Membros. Isto é chamado de “pedido permanente”. Os Serviços dos Membros irão documentar a sua solicitação permanente no seu registo de membro para que possa receber materiais agora e no futuro no seu idioma e/ou preferido. Pode alterar ou excluir a sua solicitação permanente a qualquer momento ao ligar para os Serviços dos Membros.

Se está a ter problemas para obter informações do nosso plano devido a problemas de idioma ou deficiência e deseja registar uma reclamação, ligue para:

- Medicare através do 1-800-MEDICARE (1-800-633-4227). Pode ligar 24 horas por dia, 7 dias por semana. Hoje utilizadores TTY devem ligar para o número 1-877-486-2048.
- Medicaid para registar uma reclamação, através do Rhode Island Medicaid, entre em contato com o escritório do Departamento de Serviços Humanos de Rhode Island

(DHS) através do número 1-855-697-4347 (TTY 711). Também pode ir ao escritório local do DHS para obter assistência pessoalmente. Ligue para o número 1-855-697-4347 (TTY 711) para encontrar o escritório do DHS mais próximo de si.

- Escritório de Direitos Civis através do número 1-800-368-1019 ou TTY 1-800-537-7697.

យើងត្រូវតែធានាថា សេវាកម្ម**ទាំងអស់** ត្រូវបានផ្តល់ជូនទៅអ្នកតាមរបៀបដែលអាចប្រើបាន និងសមស្រប តាមវប្បធម៌។ យើងត្រូវតែប្រាប់អ្នកអំពីអត្ថប្រយោជន៍របស់គម្រោង និងសិទ្ធិរបស់អ្នកតាមវិធីដែលអ្នកអាចយល់ទៅបាន។ ពួកយើងត្រូវតែប្រាប់អ្នកអំពីសិទ្ធិរបស់អ្នកនៅរៀងរាល់ឆ្នាំដែលអ្នកស្ថិតក្នុងគម្រោងរបស់យើង។

- ដើម្បីទទួលព័ត៌មានក្នុងវិធីដែលអ្នកអាចយល់បាននោះ ទូរសព្ទសេវាសមាជិក។ គម្រោងរបស់យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដែលអាចរកបានដើម្បីឆ្លើយសំណួរនានាជាភាសាផ្សេងៗ។

- គម្រោងរបស់យើងក៏អាចផ្តល់ជូនអ្នកនូវឯកសារនានាជាភាសាក្រៅពីភាសាអង់គ្លេស និងជាទម្រង់ដូចជា ពុម្ពអក្សរធំ អក្សរស្ទាបសម្រាប់ជនពិការភ្នែក ឬជាសំឡេង។

- គម្រោងរបស់យើងខ្ពស់អាចផ្តល់ខ្លឹមសារឱ្យអ្នកជាភាសាអេស្ប៉ាញ ព័រទុយហ្គាល់ និងភាសាខ្មែរ/កម្ពុជាផងដែរ។ លោកអ្នកអាចស្នើសុំឯកសារនេះ និងសម្ភារក្នុងពេលអនាគតជាភាសាដែលលោកអ្នកចង់បាន និង/ឬ ទម្រង់ផ្សេងទៀត
  តាមរយៈការហៅទូរស័ព្ទទៅកាន់ផ្នែកសេវាបម្រើសមាជិក។ គេហៅថា
  "សំណើសុំមានសុពលភាពជាអចិន្ត្រៃយ៍"។
  ផ្នែកសេវាបម្រើសមាជិកនឹងបញ្ចូលឯកសារសំណើសុំមានសុពលភាពជាអចិន្ត្រៃយ៍របស់អ្នកទៅក្នុងកំណត់ត្រាសមាជិករបស់អ្នក ដើម្បីឱ្យអ្នកអាចទទួលឯកសារបាននៅពេលនេះ
  និងនាពេលអនាគតក្នុងភាសាដែលអ្នកចង់បាន និង/ឬទម្រង់ដែលអ្នកចង់បាន។
  លោកអ្នកអាចប្តូរ ឬលុបការស្នើសុំជាអចិន្ត្រៃយ៍របស់អ្នក នៅពេលណាមួយក៏បាន
  តាមរយៈការហៅទូរសព្ទមកផ្នែកសេវាបម្រើសមាជិក។

ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើង ដោយសារតែបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់ដាក់ពាក្យបណ្តឹង ចូរទូរសព្ទទៅ៖

- Medicare តាមរយៈ1-800-MEDICARE (1-800-633-4227)។ អ្នកអាចទូរសព្ទមក 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកប្រើ TTY គួរតែហៅទូរសព្ទទៅកាន់លេខ 1-877-486-2048។

- Medicaid តាមលេខ ដើម្បីដាក់ពាក្យបណ្តឹងជាមួយនឹង Rhode Island Medicaid ចូរទាក់ទងទៅកាន់ការិយាល័យនៃក្រសួងសេវាមនុស្សជាតិនៃរដ្ឋ Rhode Island (Rhode Island Department of Human Services, DHS) តាមលេខ 1-855-697-4347 (TTY 711)។
  អ្នកក៏អាចទៅកាន់ការិយាល័យ DHS ក្នុងតំបន់របស់អ្នកសម្រាប់ជំនួយដោយផ្ទាល់។
  ទូរសព្ទទៅកាន់ 1-855-697-4347 (TTY 711) ដើម្បីស្វែងរកការិយាល័យ DHS
  ដែលជិតអ្នកបំផុត។

ការិយាល័យសិទ្ធិស៊ីវិល (Office of Civil Rights) តាមលេខ 1-800-368-1019 or TTY 1-800-537-7697។

B. Our responsibility to ensure that you get timely access to covered services and drugs

As a Member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You can find more information about choosing a PCP in Chapter 3.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which providers are accepting new patients.
- We do not require you to get referrals.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

You have rights related to your information and to control how your PHI is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your PHI.

C1. How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

Except for those cases noted below, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to Federal laws.
- We are required to report anonymous medical information about members' health care use and costs to Rhode Island All Payer Claims Database (APCD), HeathFacts RI. Personal information, such as your name, social security number, address, date of birth, and Neighborhood INTEGRITY member ID number is never reported. If you choose to you have your information not included, you can opt-out by visiting their website at www.riapcd-optout.com. If you would like to opt-out over the phone, call the RI Health Insurance Consumer Support Line (RI-REACH) at 1-855-747- 3224.

C2. You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.

You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

D. Our responsibility to give you information about the plan, its network providers, and your covered services

As a Member of Neighborhood INTEGRITY, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-844-812-6896 (TTY 711). This is a free service. Our plan can also give you materials in Spanish, Portuguese, and Khmer/Cambodian. We can also give you information in large print, braille, or audio.

If you want information about any of the following, call Member Services:

- Our plan, including:
  - financial information
  - how the plan has been rated by plan Members
  - the number of appeals made by Members
  - how to leave the plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
  - a list of providers and pharmacies in the plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at www.nhpri.org/INTEGRITY.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) and about rules you must follow, including:
  - services and drugs covered by the plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to Chapter 9), including asking us to:

- put in writing why something is not covered
- change a decision we made
- pay for a bill you got

E. Neighborhood INTEGRITY's Quality Improvement Program

We want to make sure you have access to high quality health care. Our Quality Improvement Program tracks important aspects of your care. We check the quality of care and services you receive. We are always working to improve quality. We send our members and providers reminders about flu shots, keeping doctor's visits, taking your medications, eating health as well as specific information for conditions such as Asthma, Diabetes, and Heart Failure.

We want to make sure you have:

- Easy access to quality medical and behavioral care
- Preventive health programs that meet your needs
- Help with any chronic conditions or illnesses you have
- Support when you need it most, such as after hospital visits or when you are sick
- High satisfaction with your providers and the health plan

One of the ways we measure how well we are doing is through HEDIS® measures. HEDIS stands for Healthcare Effectiveness Data and Information Set. HEDIS data help us track things like how often our members see their primary care provider, take their asthma medications or have important health screenings. In addition, we meet with members and providers to get suggestions for quality improvement activities that address member concerns. Our Quality Improvement Program and activities are reviewed by Neighborhood's Clinical Affairs Committee and are submitted to Neighborhood's Board of Directors.

F. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay less than the provider charged us. The only exception to this is if you are getting long-term services and supports (LTSS) and Rhode Island Medicaid says that you have to pay part of the cost of these services. This is called "cost-share," and the amount is determined by Rhode Island Medicaid. To learn what to do if a network provider tries to charge you for covered services, refer to Chapter 7.

G. Your right to leave the plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- Refer to Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- If you leave our plan, you will get your Medicaid services directly through Rhode Island Medicaid Fee for Service (FFS). For more information about Rhode Island Medicaid FFS, call 1-855-697-4347 Mon-Fri, 8:30 am - 3:30 pm.

H. Your right to make decisions about your health care

H1. Your right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers. Your provider must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all kinds of treatment for your health conditions.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another provider before deciding on treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your provider advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.

- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section E2 tells how to ask the plan for a coverage decision.

H2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you**.
- **Give your provider written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your provider, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid, such as The POINT, may also have advance directive forms. You can also go to Rhode Island's Department of Health website at health.ri.gov/lifestages/death/about/endoflifedecisions/ to get the form.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your provider. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

H3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a provider or hospital did not follow the instructions in it, you may file a complaint with the Rhode Island Department of Health by calling 1-401-222-5960 (TTY 711) or by mail at:

Department of Health

3 Capitol Hill

Providence, RI 02908

I. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other Members have filed against our plan. To get this information, call Member Services.

I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed on page 211 – or you would like more information about your rights, you can get help by calling:

- Member Services.
- The POINT at 1-401-462-4444 (TTY 711). The POINT provides information and referrals for programs and services for seniors, adults with disabilities, and their caregivers.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- RIPIN Healthcare Advocate. For details about this organization and how to contact it, refer to Chapter 2, Section I.
- The Alliance for Better Long Term Care. For details about this organization and how to contact it, refer to Chapter 2, Section J.
- Rhode Island Medicaid at 1-855-697-4347 TTY users should call 711.

J. Your responsibilities as a Member of the plan

As a Member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs.
    - Covered services, refer to Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.

- Covered drugs, refer to Chapters 5 and 6.

- **Tell us about any other health or prescription drug coverage** you have**.** We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.

- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.

- **Help your doctors** and other health care providers give you the best care**.**

  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.

  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.

  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.

- **Be considerate.** We expect all our Members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.

- **Pay what you owe.** As a plan Member, you are responsible for these payments:

  - Medicare Part A and Medicare Part B premiums. For most Neighborhood INTEGRITY Members, Medicaid pays for your Part A premium and for your Part B premium.

  - If you get LTSS, you may have to pay for part of the cost of your services. This is called "cost-share," and the amount is determined by Rhode Island Medicaid.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.

  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Neighborhood INTEGRITY. Chapter 1, Section D tells about our service area.

  - We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location.

- Also, be sure to let Medicare and Medicaid know your new address when you move. Refer to Chapter 2 for phone numbers for Medicare and Medicaid.
- **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

- Call Member Services for help if you have questions or concerns.

K. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at Neighborhood INTEGRITY Member Services. Phone numbers are at the bottom of this page.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- You can also call the Rhode Island Office of Program Integrity at 1-401-462-6503 or, The Department of Rhode Island Attorney General for reports on Medicaid fraud, patient abuse or neglect or drug diversion at 1-401-222-2556 or 1-401-274-4400 ext. 2269 or,
- Neighborhood's Compliance Officer at 1-401-459-6162 (TTY 711) or,
- Neighborhood's Compliance Hotline at 1-888-579-1551.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you are having a problem with your care, you can call RIPIN Healthcare Advocate at 1-855-747-3224 (TTY 711) for help.** This chapter explains the different options you have for different problems and complaints, but you can always call the RIPIN Healthcare Advocate to help guide you through your problem.

For additional resources to address your concerns and ways to contact them, refer to Chapter 2, Section I for more information on RIPIN Healthcare Advocate.

Table of Contents

A. What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medicaid approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

A1. About the legal terms

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to call for help

B1. Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the RIPIN Healthcare Advocate

If you need help, you can always call the RIPIN Healthcare Advocate. The RIPIN Healthcare Advocate is an ombudsman program that can answer your questions and help you understand what to do to handle your problem. Refer to Chapter 2, Section I for more information on ombudsman programs.

The RIPIN Healthcare Advocate is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the RIPIN Healthcare Advocate is 1-855-747-3224 (TTY 711). The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP) and the Medicare-Medicaid Enrollment Supports (MME) Program

You can also call the State Health Insurance Assistance Program (SHIP) to speak with a SHIP counselor about Medicare. In Rhode Island, the SHIP is provided by the Office of Healthy Aging (OHA).

The SHIP has trained counselors in every state, and services are free. To speak with a SHIP counselor, call 1-888-884-8721 (TTY 711) and their website is visit www.oha.ri.gov.

The Medicare-Medicaid Enrollment Supports Program (MME) gives free one-on-one health insurance counseling to people with Medicare and Medicaid. In Rhode Island, the MME is provided by The POINT. To speak with an MME counselor, call 1-401-462-4444 (TTY 711).

For more information, refer to Chapter 2.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. The call is free.
- Visit the Medicare website at www.medicare.gov.

Getting help from Medicaid

You can also get help from Medicaid. Contact the Rhode Island Department of Human Services (DHS) Information Line at 1-855-697-4347 (TTY 711) for help with Medicaid and DHS Long-Term Services and Supports (LTSS) at 1-401-574-9915 for help with Medicaid LTSS.

Getting help from Rhode Island's Quality Improvement Organization (QIO)

Rhode Island has an organization called KEPRO. The organization is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KEPRO is not connected with Neighborhood INTEGRITY.

- Call 1-888-319-8452, 9 am to 5 pm, Monday – Friday; 11 am to 3pm on Saturday, Sunday, and holidays. A voicemail is available 24 hours a day. TTY users call 1-855-843-4776. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
- Mail to:
  KEPRO
  5700 Lombardo Center Drive, Suite 100
  Seven Hills, OH 44131
- Visit the KEPRO website at: www.keproqio.com/

C. Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way in which they are covered, and problems related to payment for medical care.)	
Yes. My problem is about benefits or coverage. Refer to Section D: **"Coverage decisions and appeals"** on page 161.	**No.** My problem is not about benefits or coverage. Skip ahead to Section J: **"How to make a complaint"** on page 200.

D. Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment).

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your provider are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before the provider gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medicaid. If you or your provider disagree with our decision, you can appeal.

D2. Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Member Services** at 1-844-812-6896.
- Call the **RIPIN Healthcare Advocate** for free help. The RIPIN Healthcare Advocate helps people enrolled in Medicaid with service or billing problems. The phone number is 1-855-747-3224 (TTY 711).
- Call **The POINT** for free help. The POINT is an independent organization. It is not connected with this plan. The phone number is 1-401-462-4444 (TTY 711).
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask them to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form.
    - You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf **or** www.nhpri.org/wp-content/uploads/2019/04/2017-INTEGRITY-AOR-Form-CMS1696-1.pdf. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
    - However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- Section E on page 165 gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
    - You are not getting medical care you want, and you believe our plan covers this care.
    - We did not approve services, items, or drugs that your provider wants to give you, and you believe this care should be covered.
        - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with a "**DP**" are **not** covered by Part D. Refer to Section F on page 177 for Part D drug appeals.
    - You got medical care or services you think should be covered, but we are not paying for this care.
    - You got and paid for medical services or items you thought were covered, and you want to ask us to pay you back.
    - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
        - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 187 and 193.
    - Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal

- Section F on page 177 gives you information about Part D drugs. For example, use this section if:
    - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
    - You want to ask us to waive limits on the amount of the drug you can get.
    - You want to ask us to cover a drug that requires prior authorization (PA) approval.
    - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
    - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- Section G on page 187 gives you information on how to ask us to cover a longer inpatient hospital stay if you think the provider is discharging you too soon. Use this section if:
    - You are in the hospital and think the provider asked you to leave the hospital too soon.
- Section H on page 193 gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Member Services at 1-844-812-6896.

If you need other help or information, please call the RIPIN Healthcare Advocate at 1-855-747-3224 (TTY 711).

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term care services. You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the Drug List with a "**DP**" are **not** covered by Part D. Use Section F for Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. You think we cover a medical, behavioral health, or long-term care service you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 166 for information on asking for a coverage decision.

2. We did not approve care your provider wants to give you, and you think we should have.

   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 168 for information on making an appeal.

3. You got services or items that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to Section E3 on page 168 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

   What you can do: You can ask us to pay you back. Refer to Section E5 on page 176 for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

   What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 on page 168 for information on making an appeal.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections G or H on pages 187 and 193 to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health, or long-term care service

To ask for a coverage decision, call, write, or fax us, or ask your representative or provider to ask us for a decision.

- You can call us at: 1-844-812-6896 TTY 711
- You can fax us at: 1-401-459-6023
- You can write to us at:

  Neighborhood Health Plan of Rhode Island

  Attention: Utilization Management

  910 Douglas Pike

  Smithfield, RI 02917

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

> **The legal term** for "fast coverage decision" is **"expedited determination."**

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-844-812-6896 (TTY 711) or fax us at 1-401-459-6023. For details on how to contact us, refer to Chapter 2, Section A.
- You can also have your provider or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for medical care or an items and/or services you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for items or services you already got.)
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function**.
    - If your provider says that you need a fast coverage decision, we will automatically give you one.
    - If you ask for a fast coverage decision without your provider's support, we will decide if you get a fast coverage decision.
        - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
        - This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give a fast coverage decision.
        - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J on page 200.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can appeal. In all cases, you must start your appeal at Level 1.

If you need help during the appeals process, you can call RIPIN Healthcare Advocate at 1-855-747-3224 (TTY 711). The RIPIN Healthcare Advocate is not connected with us or with any insurance company or health plan.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review your coverage decision to find out if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

At a glance: How to make a Level 1 Appeal

You, your provider, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 1-844-812-6896. For additional details on how to reach us for appeals, refer to Chapter 2, Section A.
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
    - You can submit a request to the following address:

Neighborhood Health Plan of Rhode Island

Attention: Grievance and Appeals Coordinator

910 Douglas Pike

Smithfield, RI 02917

- You may also ask for an appeal by calling us at 1-844-812-6896.

> **The legal term** for "fast appeal" is **"expedited reconsideration."**

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf **or** www.nhpri.org/wp-content/uploads/2019/04/2017-INTEGRITY-AOR-Form-CMS1696-1.pdf.

If the appeal comes from someone besides you or your doctor or other provider, we must get the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Level 1 appeals" on page 171 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at 1-844-812-6896.

Can my provider give you more information about my appeal?

Yes, you and your provider may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your provider for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 200.
- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 171.

If our answer is Yes to part or all of what you asked for, we must approve or give you the service or item as soon as your health condition requires but no later than 72 hours from the date we receive the decision (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 171.

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 200.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 171.

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage as soon as your health condition requires but no later than 72 hours from the date we make the decision.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 171.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits for the service. You must **make the request on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice of action; **or**
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service while your appeal is processing. If your benefits are continued and the final result of the appeal upholds our action, we may recover the cost of the services provided to you while the appeal was pending.

E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare and/or Medicaid.

- If your problem is about a Medicare service or item, you will automatically get a Level 2 Appeal with an Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a Medicaid service or item, you can file a Level 2 Appeal with the EOHHS (Executive Office of Health and Human Services) State Fair Hearing Office. In many cases, you can also ask for a RI External Review. If you can ask for a RI External Review, the letter we send you giving you our Level 1 Appeal decision will tell you how to do this. If you're not sure whether you can request a RI External Review, you can contact us at 1-844-812-6896 and TTY 711. Information is also below. Both State Fair Hearings and RI External Reviews are conducted by independent organizations that are not part of the plan.
- If your problem is about a service or item that could be covered by both Medicare and Medicaid, you will automatically get a Level 2 Appeal with the IRE. You can also ask for a Level 2 Appeal with the State Fair Hearing office and/or the RI External Review organization. The letter we send you giving you our Level 1 Appeal decision will tell you how to do this. Information is also below.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan. If your problem is about a **Medicare** service or item, the Level 2 Appeal is done by an independent organization that is called an Independent Review Entity (IRE). The IRE is an independent organization hired by Medicare. It is not a government agency. Medicare oversees its work. If your problem is about a **Medicaid** service or item, you can ask for a Level 2 Appeal with the EOHHS State Fair Hearing office and/or the RI External Review organization.

My problem is about a Medicaid service or item. How can I make a Level 2 Appeal?

A Level 2 Appeal for a Medicaid service or item is the second appeal which is done by either an EOHHS State Fair Hearing or a RI External Review organization. You can file for either or both of these Level 2 appeals within **120 calendar days** of the mailing date of our Level 1 decision. When the Level 2 review is complete, you will receive a decision in writing.

If you miss this deadline and have a good reason for missing it, EOHHS or the RI External Review organization may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

NOTE: If we continued your benefits for the disputed service while your Level 1 Appeal was processing, **you have fewer days to appeal.** If you want to keep getting that service during the Level 2 Appeal, read "Will my benefits continue during Level 2 appeals" on page 174 for more information.

How do I make a Level 2 Appeal: EOHHS State Fair Hearing?

To start your Level 2 appeal, you, your doctor or other provider, or your representative must complete a form to request a hearing within 120 days of the mailing date of our Level 1 decision.

You or your representative can ask for the form:

- By calling the Executive Office of Health and Human Services (EOHHS) Appeals Office at (401) 462-2132 (TTY 711).
- By emailing your request to OHHS.AppealsOffice@ohhs.ri.gov.
- By faxing the request to (401) 462-0458.
- You may also call the RIPIN Healthcare Advocate at 1-855-747-3224 (TTY 711) for assistance.

The State Fair Hearing form may be mailed, faxed, or emailed.

You can also ask for an expedited (fast) State Fair Hearing on the form.

You can submit an appeal request to the following address:

EOHHS Appeals Office, Virks Building, 3 West Rd., Cranston, RI 02920

The State Fair Hearing office will schedule a hearing. They will send you a notice with the date, time, and location of the hearing no later than 15 days prior to the hearing date.

How do I make a Level 2 Appeal: RI External Review?

You can request a RI External Review by contacting us at 1-844-812-6896 and TTY 711 within four (4) months of the mailing date of our Level 1 decision. We will forward the appeal information to the RI External Review organization within five business days of receiving your request for a RI External Review. You will receive a written decision back from the RI External Review organization within 10 business days after they receive all of the information needed to review your case, but no later than 45 days from when they received the request.

Some appeal denials aren't eligible for a RI External Review. If you're not sure whether you can request a RI External Review, you can contact us at 1-844-812-6896 and TTY 711. We can help you figure out whether a RI External Review is available for your situation.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at 1-844-812-6896.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

What if my service or item could be covered by both Medicare and Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your Level 2 Appeal to the Independent Review Entity (IRE). The IRE will make a decision about whether Medicare should cover the service or item. You can also file a Level 2 Appeal with EOHHS for a State Fair Hearing or with the RI External Review organization. Follow the instructions on page 172.

Will my benefits continue during Level 2 appeals?

If your problem is about a service covered by Medicare only, your benefits for that service will **not** continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service covered by Medicaid or a service that could be covered by both Medicare and Medicaid, your benefits for that service will continue if:

- You qualified for continuation of benefits during your Level 1 Appeal;
- You file your Level 2 Appeal and ask for your benefits to continue **within 10 days** of the mailing date of our Level 1 decision. You can ask us to continue your benefits by calling us at 1-844-812-6896 or by submitting a request in writing to Neighborhood Health Plan of Rhode Island, Attention: Grievance and Appeals Coordinator, 910 Douglas Pike, Smithfield, RI 02917 or Fax: 1-401-709-7005.

If you meet these requirements, you can keep getting the disputed service while your appeal is processing. If your benefits are continued and the final result of the appeal upholds our action, we may recover the cost of the services provided to you while the appeal was pending.

When will I find out about the decision?

You will be sent a letter explaining the decision of a State Fair hearing within 90 days from the date you asked for the hearing. You will be sent a letter explaining the decision of a RI External Review within 10 days after they receive all of the information needed to review your case but no later than 45 days from when they received the appeal. If you qualify for an expedited State Fair Hearing, EOHHS must give you an answer within 72 hours. If you qualify for an expedited RI External Review, you will be given an answer in 48 hours. However, if EOHHS or the RI External Review organization needs to gather more information that may help you, it can take up to 14 more calendar days.

- If the appeal decision is **Yes** to part or all of what you asked for in your standard appeal, we must approve or give you the service or item as soon as your health condition requires but no later than 72 hours from the date when we receive the decision.
- If the appeal decision is **No** to part or all of what you asked for, it means EOHHS or the RI External Review organization confirmed the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If your Level 2 Appeal went to the Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage as soon as your health condition requires but no later than 72 hours from the date we receive the decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if the EOHHS State Fair Hearings office and/or RI External Review organization and the Independent Review Entity both review the Level 2 Appeal and make different decisions?

If the EOHHS State Fair Hearing office, RI External Review organization or the Independent Review Entity decides **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is No for all or part of what I asked for, can I make another appeal?

Yes, in some cases.

If your Level 2 appeal went to the EOHHS State Fair Hearing office and/or the RI External Review organization and they said no to part or all of your Level 2 Appeal, for a Medicaid service, item, or drug, you can file a Level 3 Appeal. We will send you a letter that will tell you how to do this. Level 3 of the appeals process for a Medicaid service, item, or drug is in State Court. Refer to Section I2 on page 200 for more information.

If your Level 2 Appeal went to the Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have. Refer to Section I1 on page 199 for more information.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only exception to this is if you are getting long-term services and supports and Rhode Island Medicaid says that you have to pay part of the cost of these services. This is called “cost-share,” and the amount is determined by Rhode Island Medicaid. If you are getting long-term services and supports, you may also have to pay part of the cost of the services. The amount is determined by Rhode Island Medicaid. This is called “cost-share,” and the amount is determined by Rhode Island Medicaid.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: “When a network provider sends you a bill.” Chapter 7, Section A describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items. The only amount you ever have to pay is your share of the cost of long-term services and supports. This is called “cost-share,” and the amount is determined by Rhode Island Medicaid.

If you are asking to be paid back, you are asking for a coverage decision. We will find out if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request. If you haven’t paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it’s the same as saying **Yes** to your request for a coverage decision.

- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 168. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 199 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicaid, you can file a Level 2 Appeal yourself (refer to Section E4 on page 171).

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a Member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs with a "**DP**". These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with "**DP**" symbol follow the process in Section E on page 165.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan's Drug List
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> **The legal term** for a coverage decision about your Part D drugs is **"coverage determination."**

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you already got and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with Section F2 on page 179. Also refer to Sections F3 and F4 on pages 180 and 181.	Skip ahead to Section F4 on page 181.	Skip ahead to Section F4 on page 181.	Skip ahead to Section F5 on page 184.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our Drug List.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5, Section C).
   - The extra rules and restrictions on coverage for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.

- Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization” (PA).)
- Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
- Quantity limits. For some drugs, we limit the amount of the drug you can have.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **“formulary exception.”**

F3. Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your provider continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 184 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You can call us at 1-844-812-6896. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D2 on page 162 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7, Section A of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A **standard coverage decision** means we will give you **an answer within 72 hours** after we get your provider's statement.

- A **fast coverage decision** means we will give you **an answer within 24 hours** after we get your provider's statement.

> **The legal term** for "fast coverage decision" is **"expedited coverage determination."**

You can get a fast coverage decision **only if you are asking for a drug you have not yet received**. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision **only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.**

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 200.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No.** The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-844-812-6896.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at 1-844-812-6896.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. *You may also ask for an appeal by calling us.*

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section F4 on page 181.

The legal term for "fast appeal" is **"expedited redetermination."**

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
    - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
    - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- If our answer is No to part or all of what you asked for, we will send you a letter that explains why we said No and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at 1-844-812-6896.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your provider and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your provider or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called "An Important Message from Medicare about Your Rights." If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services at 1-844-812-6896. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The "Important Message" tells you about your rights as a hospital patient, including your rights to:

- Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your provider or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-844-812-6896. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
- You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal.

A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you. In Rhode Island, the Quality Improvement Organization is called KEPRO.

To make an appeal to change your discharge date call KEPRO at: 1-888-319-8452.

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. "An Important Message from Medicare about Your Rights" contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4 on page 191.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-319-8452 and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-844-812-6896. You can also call the RIPIN Healthcare Advocate at 1-855-747-3224 (TTY 711), the State Health Insurance Assistance Program (SHIP) at 1-888-884-8721 (TTY 711), or The POINT at 1-401-462-4444 (TTY 711).

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for "fast review" is **"immediate review."**

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your provider, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your provider, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at 1-844-812-6896. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Rhode Island, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-319-8452.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-319-8452 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

G4. What happens if you miss an appeal deadline

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a "fast review."

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say Yes to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
    - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 200 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

- With any of these three types of care, you have the right to keep getting covered services for as long as the provider says you need it.
- When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying .

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 200 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at 1-844-812-6896. Or call your State Health Insurance Assistance Program at 1-401-462-4444.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Rhode Island, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-319-8452. Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-888-319-8452 and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a "fast-track appeal." This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4 on page 197.

The **legal term** for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at 1-844-812-6896 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or refer to a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.

- The reviewers will also look at your medical records, talk with your provider, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> **The legal term** for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."**

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In Rhode Island, the Quality Improvement Organization is called KEPRO. You can reach KEPRO at: 1-888-319-8452. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for Rhode Island at 1-888-319-8452 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."

At a glance: How to make a Level 1 Alternate Appeal

Call our Member Services number and ask for a "fast review."

We will give you our decision within 72 hours.

- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary. It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

> **The legal term** for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 200 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.

At a glance: How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

I. Taking your appeal beyond Level 2

I1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the RIPIN Healthcare Advocate. The phone number is 1-855-747-3224 (TTY 711).

I2. Next steps for Medicaid services and items

You also have more appeal rights if your appeal is about services, items, or drugs that might be covered by Medicaid. If the EOHHS State Fair Hearing office or the RI External Review organization says no to part or all of your Level 2 Appeal, for a Medicaid service, item, or drug, you can file a Level 3 Appeal. We will send you a letter that will tell you how to do this. Level 3 of the appeals process for a Medicaid service, item, or drug is in State Court.

For more information on how to go to the next level of appeal, contact us at 1-844-812-6896 and TTY 711. You can also ask the RIPIN Healthcare Advocate for help. The phone number is 1-855-747-3224 (TTY 711).

J. How to make a complaint

J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Neighborhood INTEGRITY staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 202.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

> **The legal term** for a "complaint" is a **"grievance."**
>
> **The legal term** for "making a complaint" is **"filing a grievance."**

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the RIPIN Healthcare Advocate at 1-855-747-3224 (TTY 711).

J2. Internal complaints

To make an internal complaint, call Member Services at 1-844-812-6896. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we do not agree with some or all of your complaint, **we will tell you** and give you our reasons. We will respond whether we agree with the complaint or not.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell the Rhode Island Department of Health or the Rhode Island Office of the Health Insurance Commissioner about your complaint

You can file a complaint with the Rhode Island Department of Health by calling them at 1-401-222-2231 (TTY 711). You can also file a complaint with the Rhode Island Office of the Health Insurance Commissioner by calling them at 1-401-462-9517 (TTY 711).

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the following local civil rights offices:

- Rhode Island Commission for Human Rights at 1-401-222-2661. TTY users should call 1-401-222-2664. You can visit www.richr.ri.gov for more information.
- Rhode Island Department of Human Services Community Relations Liaison Officer at 1-401-415-8500. TTY users should call 1-401-462-6239 or 711.
- Office for Civil Rights (OCR) New England Region at 1-800-368-1019. TTY users should call 1-800-537-7697.

You may also have rights under the Americans with Disability Act. You can contact RIPIN Healthcare Advocate for assistance. The phone number is 1-855-747-3224 (TTY 711).

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2, Section F. In Rhode Island, the Quality Improvement Organization is called KEPRO. The phone number for KEPRO is 1-888-319-8452.

Chapter 10: Ending your membership in our Medicare-Medicaid Plan

Introduction

This chapter tells you when and how you can end your membership in our plan and what your health coverage options are after you leave our plan. If you leave our plan, you will still be in the Medicare and Rhode Island Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. When you can end your membership in our Medicare-Medicaid Plan

You can end your membership in Neighborhood INTEGRITY Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan or moving to Original Medicare.

Your membership will end on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month (February 1, in this example). If you leave our plan, you can get information about your:

- Medicare options in the table on page 206.
- Rhode Island Medicaid services on page 207.

You can get more information about when you can end your membership by calling:

- Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469, Monday-Friday 8:00 am-6:00 pm. TTY users should call 711.
- State Health Insurance Assistance Program (SHIP), Office of Healthy Aging (OHA) at 1-888-884-8721. TTY users should call 711.
- Medicare-Medicaid Enrollment Supports Program (MME), The POINT, at 1-401-462-4444. TTY users should call 711.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

NOTE: If you are in a drug management program, you may not be able to change plans. Refer to Chapter 5 for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, tell Rhode Island Medicaid or Medicare that you want to leave Neighborhood INTEGRITY:

- Call Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469, Monday-Friday 8:00 am-6:00 pm. TTY users should call 711; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 206.

C. How to get Medicare and Medicaid services separately

If you leave Neighborhood INTEGRITY, you will return to getting your Medicare and Medicaid services separately.

C1. Ways to get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan or a Program of All-inclusive Care for the Elderly (PACE)	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444. TTY users should call 711. You will automatically be disenrolled from Neighborhood INTEGRITY when your new plan's coverage begins.
2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444. TTY users should call 711. You will automatically be disenrolled from Neighborhood INTEGRITY when your Original Medicare coverage begins.

3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare prescription drug plan **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444, TTY users should call 711. They will refer you to a State Health Insurance Assistance Program (SHIP) counselor.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Rhode Island SHIP at 1-888-884-8721 or The POINT at 1-401-462-4444. TTY users should call 711. You will automatically be disenrolled from Neighborhood INTEGRITY when your Original Medicare coverage begins.

C2. How to get your Medicaid services

If you leave the Medicare-Medicaid Plan, you will get your Medicaid services directly through Rhode Island Medicaid Fee for Service (FFS).

Your Medicaid services include most long-term services and supports (LTSS) and behavioral health care.

D. Keep getting your medical services and drugs through our plan until your membership ends

If you leave Neighborhood INTEGRITY, it may take time before your membership ends and your new Medicare and Rhode Island Medicaid coverage begins. During this time, keep getting your prescription drugs and health care through our plan.

- Use our network providers to receive medical care.
- **Use our network pharmacies** including through our mail-order pharmacy services **to get your prescriptions filled.**

- If you are hospitalized on the day that your membership in Neighborhood INTEGRITY ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

E. Keep getting your medical items, services and drugs through our plan until your membership ends

These are the cases when Neighborhood INTEGRITY must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Rhode Island Medicaid. Our plan is for people who qualify for both Medicare and Rhode Island Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a Member of our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a Member on this basis.
    - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Rhode Island Medicaid first:

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other Members of our plan.
- If you let someone else use your Member ID Card to get medical care.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

F. Rules against asking you to leave our plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week. You should also call Rhode Island Medicaid. The Medicare-Medicaid Plan Enrollment Line is 1-844-602-3469, 8:30 am to 6 pm, Monday – Friday. TTY users should call 711.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9, Section J for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at 1-844-812-6896 (TTY 711).

Click or tap here to enter text.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in Neighborhood INTEGRITY. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation. In addition, you cannot be treated differently because of your health care appeals, behavior, gender identity, gender expression, mental ability, receipt of health care, or use of health care services.

It is our responsibility to treat you with dignity and respect at all times. If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.
- You can also call your local Office for Civil Rights.
    - Rhode Island Commission for Human Rights at 1-401-222-2661. TTY users should call 1-401-222-2664. You can visit www.richr.ri.gov for more information.
    - Rhode Island Department of Human Services Community Relations Liaison Officer at 1-401-415-8500. TTY users should call 1-401-462-6239 or 711.

If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9, Section D explains appeals, including how to make an appeal.

Assessment: A review of a patient's health care history and current condition. It is used to figure out the patient's health and how it might change in the future.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar: A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: A plan for what health services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9, Section D explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports (LTSS), supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our Drug List. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of 3 tiers.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function and if you are a pregnant woman, loss of an unborn child. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem in court or the State Fair Hearing Office and show that a decision we made is wrong.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has a care manager to help you manage all your providers and services. They all work together to provide the care you need.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- Neighborhood INTEGRITY must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Neighborhood INTEGRITY Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

Because Neighborhood INTEGRITY pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

List of Covered Drugs **(Drug List):** A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income Subsidy (LIS): Refer to "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports (LTSS) and medical costs.

- It covers extra services and drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- Refer to Chapter 2, Section H for information about how to contact Medicaid in your state.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage Plan: A Medicare program, also known as "Medicare Part C" or "MA Plans," that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dually eligible individual."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and provider visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Neighborhood INTEGRITY includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (Member of our plan, or plan Member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments or riders, which explain your coverage, what we must do, your rights, and what you must do as a Member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2, section A for information about how to contact Member Services.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan Member. We call them "network pharmacies" because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our Members an extra amount.
- While you are a Member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information about the ombudsman in Chapters 2 and 9 of this handbook.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9, Section D explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to Members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to Members of our plan. Chapter 3, Section D explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to Neighborhood INTEGRITY's Notice of Privacy Practices for more information about how Neighborhood INTEGRITY protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you use first for most health problems.

- They make sure you get the care you need to stay healthy. They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to Chapter 3, Section D for information about getting care from primary care providers.

Prior authorization (PA): An approval from Neighborhood INTEGRITY you must get before you can get a specific service or drug or use an out-of-network provider. Neighborhood INTEGRITY may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets PA from our plan.

- Covered services that need PA are marked in the Benefits Chart in Chapter 4, Section F.

Some drugs are covered only if you get PA from us.

- Covered drugs that need PA are marked in the *List of Covered Drugs.*

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. Refer to Chapter 2, Section F for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. Refer to Chapter 4, Section D to learn more about rehabilitation services.

Rhode Island Executive Office of Health and Human Services (EOHHS): The state agency responsible for administering the Medicaid program in Rhode Island. Chapter 2, Section H explains how to contact EOHHS.

Service area: A geographic area where a health plan accepts Members if it limits membership based on where people live. For plans that limit which providers and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Neighborhood INTEGRITY's service area is the State of Rhode Island. Only people who live in our service area can get Neighborhood INTEGRITY. If you move outside of Rhode Island, you cannot stay in this plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A provider who provides health care for a specific disease or part of the body.

State Medicaid agency: Refer to "Rhode Island Executive Office of Health and Human Services."

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Neighborhood INTEGRITY Member Services

CALL	1-844-812-6896 Calls to this number are free. 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday On Saturday afternoons, Sundays, and holidays you may be asked to leave a message. Your call will be returned within the next business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays, and holidays you may be asked to leave a message. Your call will be returned within the next business day.
WRITE	Neighborhood Health Plan of Rhode Island 910 Douglas Pike Smithfield, RI 02917
WEBSITE	www.nhpri.org/INTEGRITY